SERFF Tracking Number:	*STAR-126385934*	*State:*	*Arkansas*
Filing Company:	*Starmount Life Insurance Company*	*State Tracking Number:*	*44096*
Company Tracking Number:			
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*Individual Dental Policy*		
Project Name/Number:	*/IDN-2009*		

Filing at a Glance

Company: Starmount Life Insurance Company

Product Name: Individual Dental Policy	SERFF Tr Num: STAR-126385934	State: Arkansas
TOI: H10I Individual Health - Dental	SERFF Status: Closed-Approved-Closed	State Tr Num: 44096
Sub-TOI: H10I.000 Health - Dental	Co Tr Num:	State Status: Approved-Closed
Filing Type: Form/Rate		Reviewer(s): Rosalind Minor
	Author: Natka Varisco	Disposition Date: 11/19/2009
	Date Submitted: 11/16/2009	Disposition Status: Approved-Closed
Implementation Date Requested:		Implementation Date:

State Filing Description:

General Information

Project Name:	Status of Filing in Domicile: Authorized
Project Number: IDN-2009	Date Approved in Domicile:
Requested Filing Mode:	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 11/19/2009	Explanation for Other Group Market Type:
	State Status Changed: 11/19/2009
Deemer Date:	Created By: Natka Varisco
Submitted By: Natka Varisco	Corresponding Filing Tracking Number:

Filing Description:

We are pleased to file the above referenced forms in Arkansas. This is a new filing and is being filed without an illustration. This policy is an individual dental care policy. The individual dental plan will be marketed as standalone coverage to individuals outside the worksite environment through the internet, individual mailers and to seniors through bank mailers or other affinity marketing, such as associations. The riders submitted will be marketed as a package with the base dental plan. The application will be placed on our Starmount website upon approval.

Company and Contact

SERFF Tracking Number:	*STAR-126385934*	*State:*	*Arkansas*
Filing Company:	*Starmount Life Insurance Company*	*State Tracking Number:*	*44096*
Company Tracking Number:			
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*Individual Dental Policy*		
Project Name/Number:	*/IDN-2009*		

Filing Contact Information

Natka Varisco, compliance specialist
7800 Office Park Blvd.
Baton Rouge, LA 70809

natkav@starmountlife.com
225-926-2888 [Phone] 219 [Ext]
225-610-1419 [FAX]

Filing Company Information

Starmount Life Insurance Company
7800 Office Park Boulevard
Baton Rouge, LA 70809
(225) 926-2888 ext. [Phone]

CoCode: 68985
Group Code: 68985
Group Name:
FEIN Number: 72-0977315

State of Domicile: Louisiana
Company Type:
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Starmount Life Insurance Company	$50.00	11/16/2009	32078622

SERFF Tracking Number:	*STAR-126385934*	*State:*	*Arkansas*
Filing Company:	*Starmount Life Insurance Company*	*State Tracking Number:*	*44096*
Company Tracking Number:			
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*Individual Dental Policy*		
Project Name/Number:	*/IDN-2009*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	11/19/2009	11/19/2009

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	**Created By**	**Created On**	**Date Submitted**	**Responded By**	**Created On**	**Date Submitted**
Pending Industry Response	Rosalind Minor	11/17/2009	11/17/2009	Natka Varisco	11/18/2009	11/18/2009

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	Individual Dental Policy	Natka Varisco	11/16/2009	11/16/2009

SERFF Tracking Number:	*STAR-126385934*	*State:*	*Arkansas*
Filing Company:	*Starmount Life Insurance Company*	*State Tracking Number:*	*44096*
Company Tracking Number:			
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*Individual Dental Policy*		
Project Name/Number:	*/IDN-2009*		

Disposition

Disposition Date: 11/19/2009
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*STAR-126385934*	*State:*	*Arkansas*
Filing Company:	*Starmount Life Insurance Company*	*State Tracking Number:*	*44096*
Company Tracking Number:			
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*Individual Dental Policy*		
Project Name/Number:	*/IDN-2009*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	No
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Form	Individual Dental Application	Approved-Closed	Yes
Form *(revised)*	Individual Dental Policy	Approved-Closed	Yes
Form	Individual Dental Policy	Replaced	Yes
Form	Individual Dental Policy	Replaced	Yes
Form	Individual Vision Rider	Approved-Closed	Yes
Form	Individual TMJ Rider	Approved-Closed	Yes
Form	Schedule of Procedures	Approved-Closed	Yes
Form	Schedule of Benefits	Approved-Closed	Yes

SERFF Tracking Number:	*STAR-126385934*	*State:*	*Arkansas*
Filing Company:	*Starmount Life Insurance Company*	*State Tracking Number:*	*44096*
Company Tracking Number:			
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*Individual Dental Policy*		
Project Name/Number:	*/IDN-2009*		

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	11/17/2009
Submitted Date	11/17/2009
Respond By Date	

Dear Natka Varisco,

This will acknowledge receipt of the captioned filing.

Objection 1

- Individual Dental Policy, IDN-2009-AR (Form)

Comment:

Coverage for newborn children must be for at least 90 days. Refer to ACA 23-79-129.

Objection 2

- Individual Dental Policy, IDN-2009-AR (Form)

Comment:

Please refer to the 60 day period for coverage provided for minors for whom the insured has filed a petition to adopt. ACA 23-79-137.

Objection 3

- Individual Dental Policy, IDN-2009-AR (Form)

Comment:

With respect to handicapped dependents, there can be no time limit set for furnishing proof of incapacity. Refer to ACA 23-85-131(4) and Bulletin 14-81.

Objection 4

- Individual Dental Policy, IDN-2009-AR (Form)

Comment:

There needs to be a provision for the refund of unearned premium in the event of death of the insured. ACA 23-85-134.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

SERFF Tracking Number:	*STAR-126385934*	*State:*	*Arkansas*
Filing Company:	*Starmount Life Insurance Company*	*State Tracking Number:*	*44096*
Company Tracking Number:			
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*Individual Dental Policy*		
Project Name/Number:	*/IDN-2009*		

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	11/18/2009
Submitted Date	11/18/2009

Dear Rosalind Minor,

Comments:

Response 1

Comments: Response to Objection No. 1:
The COVERED PERSONS provision has been changed to comply with ACA 23-79-129.
31 days has been changed to 90.

Related Objection 1

Applies To:

- Individual Dental Policy, IDN-2009-AR (Form)

Comment:

Coverage for newborn children must be for at least 90 days. Refer to ACA 23-79-129.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Individual Dental Policy	IDN-2009-AR		Policy/Contract/Fraternal Certificate	Initial		50.600	IDN-2009-AR POLICY rev1.pdf
Previous Version							
Individual Dental Policy	*IDN-2009-*		*Policy/Contract/Fraternal*	*Initial*		*50.600*	IDN-2009-

	AR	*Certificate*				AR POLICY.pdf
Individual Dental Policy	*IDN-2009-AR*	*Policy/Contract/Fraternal Certificate*	*Initial*		*50.600*	IDN-2009-AR POLICY.pdf

No Rate/Rule Schedule items changed.

Response 2

Comments: Response to Objection No. 2:
The COVERED PERSONS provision has been changed to comply with ACA 23-79-137.
31 days has been changed to 60.

Related Objection 1

Applies To:

- Individual Dental Policy, IDN-2009-AR (Form)

Comment:

Please refer to the 60 day period for coverage provided for minors for whom the insured has filed a petition to adopt. ACA 23-79-137.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Individual Dental Policy	IDN-2009-AR		Policy/Contract/Fraternal Certificate	Initial		50.600	IDN-2009-AR POLICY rev1.pdf

Previous Version

Individual Dental Policy	*IDN-2009-AR*	*Policy/Contract/Fraternal Certificate*	*Initial*	*50.600*	IDN-2009-AR POLICY.pdf
Individual Dental Policy	*IDN-2009-AR*	*Policy/Contract/Fraternal Certificate*	*Initial*	*50.600*	IDN-2009-AR POLICY.pdf

No Rate/Rule Schedule items changed.

Response 3

Comments: Response to Objection No. 3:
The COVERED PERSONS provision has been changed to comply with ACA 23-85-131(4). The time limit for furnishing proof of incapacity has been removed.

Related Objection 1

Applies To:

- Individual Dental Policy, IDN-2009-AR (Form)

Comment:

With respect to handicapped dependents, there can be no time limit set for furnishing proof of incapacity. Refer to ACA 23-85-131(4) and Bulletin 14-81.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Individual Dental Policy	IDN-2009-AR		Policy/Contract/Fraternal Certificate	Initial		50.600	IDN-2009-AR POLICY rev1.pdf

SERFF Tracking Number:	*STAR-126385934*	*State:*	*Arkansas*
Filing Company:	*Starmount Life Insurance Company*	*State Tracking Number:*	*44096*
Company Tracking Number:			
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*Individual Dental Policy*		
Project Name/Number:	*/IDN-2009*		

Previous Version

Individual Dental Policy	*IDN-2009-AR*	*Policy/Contract/Fraternal Certificate*	*Initial*	*50.600*	IDN-2009-AR POLICY.pdf
Individual Dental Policy	*IDN-2009-AR*	*Policy/Contract/Fraternal Certificate*	*Initial*	*50.600*	IDN-2009-AR POLICY.pdf

No Rate/Rule Schedule items changed.

Response 4

Comments: Response to Objection No. 4:
An UNEARNED PREMIUM provision has been added to the policy to comply with ACA 23-85-134.

Related Objection 1

Applies To:

- Individual Dental Policy, IDN-2009-AR (Form)

Comment:

There needs to be a provision for the refund of unearned premium in the event of death of the insured. ACA 23-85-134.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Individual Dental Policy	IDN-2009-AR		Policy/Contract/Fraternal Certificate	Initial		50.600	IDN-2009-AR POLICY rev1.pdf

SERFF Tracking Number:	*STAR-126385934*	*State:*	*Arkansas*
Filing Company:	*Starmount Life Insurance Company*	*State Tracking Number:*	*44096*
Company Tracking Number:			
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*Individual Dental Policy*		
Project Name/Number:	*/IDN-2009*		

Previous Version

Individual Dental Policy	*IDN-2009-AR*	*Policy/Contract/Fraternal Certificate*	*Initial*	*50.600*	IDN-2009-AR POLICY.pdf
Individual Dental Policy	*IDN-2009-AR*	*Policy/Contract/Fraternal Certificate*	*Initial*	*50.600*	IDN-2009-AR POLICY.pdf

No Rate/Rule Schedule items changed.

Additionally, I changed to DEPENDANT CHILDREN to age 26 to match the dependant age in COVERED PERSONS.

Please let me know if you need additional information.

Thank you for your help.

Natka Varisco
Compliance Specialist
Starmount Life Insurance Company
(225)926-2888 ext 219

Sincerely,
Natka Varisco

SERFF Tracking Number:	*STAR-126385934*	*State:*	*Arkansas*
Filing Company:	*Starmount Life Insurance Company*	*State Tracking Number:*	*44096*
Company Tracking Number:			
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*Individual Dental Policy*		
Project Name/Number:	*/IDN-2009*		

Amendment Letter

Submitted Date: 11/16/2009

Comments:

I replaced the policy.

Thanks,

Natka Varisco

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
IDN-2009-AR	Policy/Contract/Fraternal Certificate	Individual Dental Policy	Initial				50.600	IDN-2009-AR POLICY.pdf

SERFF Tracking Number:	*STAR-126385934*	*State:*	*Arkansas*
Filing Company:	*Starmount Life Insurance Company*	*State Tracking Number:*	*44096*
Company Tracking Number:			
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*Individual Dental Policy*		
Project Name/Number:	*/IDN-2009*		

Form Schedule

Lead Form Number: IDN-2009-AR

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 11/19/2009	IDN-2009 Application	Application/ Enrollment Form	Individual Dental Application	Initial		50.600	IDN-2009 Application.pdf
Approved-Closed 11/19/2009	IDN-2009-AR	Policy/Contract/Fraternal Certificate	Individual Dental Policy	Initial		50.600	IDN-2009-AR POLICY rev1.pdf
Approved-Closed 11/19/2009	IDNVR-2009	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Individual Vision Rider	Initial		50.300	IDNVR-2009.pdf
Approved-Closed 11/19/2009	IDNTMJ-2009	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Individual TMJ Rider	Initial		51.500	IDNTMJ-2009.pdf
Approved-Closed 11/19/2009	IDN-2009-SCP	Schedule Pages	Schedule of Procedures	Initial		50.200	IDN-2009-SCP.pdf
Approved-Closed 11/19/2009	IDN2009-SOB	Schedule Pages	Schedule of Benefits	Initial		52.200	IDN-2009-SOB.pdf

AlwaysCare℠
Flexible Dental & Vision Benefits

For Individuals
Dental Insurance Application

1. Complete all areas in the application below. **Please be sure to read all information fully and sign where indicated on back.**
2. Indicate the type of coverage you want (Individual, Individual & Spouse, etc.) and how you want to pay (automatic checking account deduction or credit card charge.)
3. Return this entire sheet in the envelope provided. **Send no money**. Once approved, your policy and ID card will be mailed or emailed to you.

Starmount Life Insurance Company

[7800 Office Park Blvd, PO Box 98100 • Baton Rouge, LA 70898-9100
Toll Free Telephone No: 1-888-729-5433]

To Be Completed by Applicant:

Applicant's Name: _____ DOB: _____ Sex: _____
Last First MI MM/DD/YYY

Applicants Address: _____ City: _____ State: _____ Zip _____
Street or Post Office Box Apt. Number

Last 4 Digits of Applicant's Social Security Number: __ __ __ __ ☐ Male ☐ Female

Name of Spouse (if to be insured):_____ DOB: ____/____/_____
Last First MI MM/DD/YYYY

☐ Male ☐ Female Home Telephone Number: (_____) _____-_____

E-mail address: _____@_____

Check Coverage Desired:

❑ Individual ❑ Individual & Children ❑ Individual & Family ❑ Individual & Spouse

Indicate Method of Payment (Checking account deduction or credit card payment only):

❑ Deduct premium payments from my checking account automatically. (My voided check is enclosed.)

❑ Charge future payments to ❑ ***Visa*** ❑ ***Mastercard***

Credit Card Number:__ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ Expiration Date (MM/YY): _____/ _____

I want to pay:

❑ Every Month ❑ Every 3 Months ❑ Every 6 Months ❑ Every 12 Months

To Be Completed on Each Dependent Child

***RELATIONSHIP-If Dependent is not your natural child, attach documentation of legal custody or adoption. If coverage is court ordered attach a copy of the order.**

Child's Name – Last, First, Middle Initial	**Date of Birth (MM/DD/YYYY)**	**Gender**	**Relationship***	**Check if:**
		❑ Male ❑ Female	☐ SON ☐ STEPSON ☐ DAUGHTER ☐ STEPDAUGHTER ☐ OTHER_____	[❑ Handicapped child ❑ Full-Time Student
		❑ Male ❑ Female	☐ SON ☐ STEPSON ☐ DAUGHTER ☐ STEPDAUGHTER ☐ OTHER_____	❑ Handicapped child ❑ Full-Time Student
		❑ Male ❑ Female	☐ SON ☐ STEPSON ☐ DAUGHTER ☐ STEPDAUGHTER ☐ OTHER_____	❑ Handicapped child ❑ Full-Time Student
		❑ Male ❑ Female	☐ SON ☐ STEPSON ☐ DAUGHTER ☐ STEPDAUGHTER ☐ OTHER_____	❑ Handicapped child ❑ Full-Time Student]

Do You have any other dental insurance in force with another company? ❑ Yes ❑ No
Is this insurance intended to replace any other insurance now in force? ❑ Yes ❑ No

APPLICATION CONTINUED ON OTHER SIDE. PLEASE READ, SIGN AND DATE WHERE INDICATED.

Applicant's Statements and Agreements

1.	I understand that the effective date of the policy will be the date recorded in the Policy Schedule of Benefits by Us.
2.	I understand the policy I am applying for contains different Waiting Periods for certain benefits listed in the Policy Schedule of Benefits. This means that no benefits are payable during the listed Waiting Period. The Waiting Period begins on the effective date of coverage.
3.	I understand that dependent children, if any, will be covered until the end of the month following their 21st birthday (24th if full-time students).
4.	I understand that: (a) Starmount Life Insurance Company is not bound by any statement made by me, the applicant, or any associate/agent of Starmount Life Insurance Company unless written herein. (b) The associate/agent cannot change the provisions of the policy or waive any of its provisions either orally or in writing. (c) The policy together with this application, endorsements, benefit agreements and riders, if any, is the entire contract of insurance. (d) No change to the policy will be valid until approved by Our president and secretary, and noted in or attached to the policy.
5.	I acknowledge receipt of, if applicable: ❑ Outline of Coverage.

Notice of Information Practices

To issue an insurance policy, We may need to obtain additional information about You and any other persons proposed for insurance. Some information will come from You and some may come from other sources. That information and any other subsequent information collected by Us may in some circumstances be disclosed to third parties without Your specific consent. You have the right to access and correct the information collected about You except information that relates to a claim or to a civil or criminal proceeding. If You wish to have a more detailed explanation of Our information practices, please submit a written request to Us. This notice applies only in Arizona,
California, Georgia, Illinois, Maine, Minnesota, Montana, Nevada, North Carolina, Oregon and Virginia.

Authorization to Obtain Information

I authorize the following to give information (defined below) to Starmount Life Insurance Company or any person or group acting on their part: any medical professional, any medical care institution, insurer, reinsurer, government agency, consumer reporting agency or employer. "Information" means facts of a medical nature in regard to my physical or mental condition, employment, or other insurance coverage, or any other nonmedical facts. I understand that this information will be used by Starmount Life Insurance Company to determine eligibility for insurance and may be used to evaluate a claim for benefits during the time it is valid. I agree that this authorization is valid for 30 (24 months in KS, OK and WV) months from the date signed. I know that I have a right to receive a copy of this authorization upon request. I agree that a copy of this authorization is as valid as the original.

I understand that the premium amount listed on this application represents the premium amount that either my employer will remit to Starmount Life Insurance Company on my behalf, or I will remit directly to them. I further understand that this amount, because of my employer's billing/payroll practices, may differ from the amount being deducted from my paycheck or the premium amount quoted to me by my associate/agent.

I also understand that if I am receiving any Medicaid benefits, the purchase of this coverage may not be necessary.

If I am applying to replace existing coverage with this policy, I acknowledge that the policies may have different benefits and that I should make a comparison to personally determine which is best for me. I understand and agree that I am terminating my current policy and its benefits for the benefits provided in the Starmount Life Insurance Company Policy. I have read, or had read to me, the completed application, and I realize policy issuance is based upon statements and answers provided herein, and they are complete and true to the best of my knowledge and belief.

I understand that any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Signed and Dated at _____ on _____
City and State Date

Applicant's Signature _____

Associate/Agent's Signature_____ Date_____
Licensed Resident Associate/Agent

Starmount Life Insurance Company

[Home Office: 7800 Office Park Blvd., P.O. Box 98100, Baton Rouge, LA 70898-9100
Administrative Office: AlwaysCare Benefits, Inc., 7800 Office Park Blvd, PO Drawer 14389
Baton Rouge, LA 70898-4389]
Toll Free Telephone No: 1-888-729-5433

LIMITED BENEFITS HEALTH INSURANCE
DENTAL INSURANCE POLICY
[with Vision and TMJ Benefits Rider]

The Named Insured as shown in the Policy Schedule will be referred to as "You", "Your" or "Yours". Starmount Life Insurance Company will be referred to as "We", "Our" or "Us".

IMPORTANT
This is a dental policy [with [Vision] and [TMJ Benefits Rider]]. Read it carefully with the Outline of Coverage, if applicable.

CONSIDERATION
This policy is issued in consideration of the statements made in Your application and the payment of the premium shown in the Policy Schedule. A copy of Your application is attached and is part of this policy. The following paragraphs set forth the insurance benefits, limitations and exclusions, definitions of terms, and other provisions.

TERM
The term of this policy begins at noon, standard time, at the place where You reside on the effective date shown in the Policy Schedule. It ends at noon, the same standard time, on the first renewal date. Each renewal term ends at noon, the same standard time, on the next following renewal date. Renewal dates are determined by the mode of payment. The mode of payment for the original term of the policy is shown in the Policy Schedule. An annual premium will maintain the policy in force for 12 months, semiannual for six months, quarterly for three months.

30-DAY RIGHT TO EXAMINE THIS POLICY
It is important to Us that You are satisfied with this policy and that it meets Your insurance goals. If You are not satisfied, You may return it within 30 days after You receive it. You will receive a full refund of all premiums paid, and Your policy will be void from its effective date. If You return the policy, please note in writing: "This policy is returned for cancellation and refund of premium."

IMPORTANT NOTICE
Please read Your application attached to this policy. This policy is issued on the basis that the information shown on the application is correct and complete to the best of Your knowledge and belief. Carefully check the application. Write to Us within 30 days of the date You receive this policy if any information shown on it is not correct or complete. Incorrect information can result in the denial of a claim or termination of the policy. No duly licensed agent may change this policy or waive any of its provisions.

GUARANTEED RENEWABLE. WE HAVE THE RIGHT TO CHANGE PREMIUM RATES.
You can keep Your policy in force as long as You pay Your premium on time. It must be paid by the due date or during the 31 day Grace Period. We may change the premium rates effective at renewal dates for Each Subsequent Policy Year. We will not change Your premium unless the same change is made on all policies of this form in the state where you live. We will notify You in writing at Your last known address at least 30 days before the change becomes effective.

THIS IS A NON-PARTICIPATING POLICY

INDEX

POLICY SCHEDULE

Insert Policy Schedule here.

Part 1
DEFINITIONS

A. CLAIM: a request for payment of benefits under this policy.

B. COVERED DENTAL EXPENSE: is the lesser of the actual charge or the Schedule Amount.

C. COVERED DENTAL PROCEDURE: any procedure listed in the Schedule of Covered Procedures.

D. COVERED PERSONS: are any persons listed in the Policy Schedule.

Newborn children are automatically covered under the terms of the policy from the moment of birth, and adopted children are covered from the date of petition. Coverage for newborn will be in effect until the 90th day following the date of such event. If You desire uninterrupted coverage for a newborn, You must notify Us within 90 days of the child's birth. Coverage for adopted will be in effect until the 60th day following the date of such event. If You desire uninterrupted coverage for an adopted child, You must notify US with 60 days of the date of petition for adoption.

Upon notification, We will convert this policy to the Type of Coverage You requested and advise You of the additional premium due, if any. If You wish any other person to be covered after the effective date of the policy, You must apply for such coverage, and that person must be added by endorsement. Insurance for persons added by endorsement becomes effective on the date specified on the endorsement.

The insurance of any Dependent Child will terminate on the policy anniversary date following the end of the month of the child's 26th birthday, the child's marriage, or at the time the child no longer qualifies as a legal dependent for tax exemption purposes under the Unites States Revenue Service Tax Code, whichever occurs first. Termination will be without prejudice to any claim originating prior hereto. Our acceptance of premium after such date will be considered as premium for only the remaining persons who qualify as covered persons under the policy. Coverage provided under a Type of Coverage listed in the Policy Schedule, which includes Dependents, will include any other unmarried dependent child, regardless of age, who is incapable of self-sustaining employment by reason of mental retardation or physical handicap and who became so incapacitated before age 26. You must furnish proof of such incapacity and dependency to Us. At Our request You must furnish proof of loss of continued incapacity and dependency, but not more often than annually after the two-year period following the end of the month of the child's 26th birthday.

In the event of Your death, Your spouse, if covered by this policy, will become the Named Insured.

E. DENTAL HYGIENIST: a legally qualified person, other than a member of Your Immediate Family, who is licensed by the state to treat the type of condition for which a claim is made.

F. DENTIST: a legally qualified person, other than a member of Your Immediate Family, who is licensed by the state to treat the type of condition for which a claim is made.

G. DEPENDENT CHILDREN: are Your natural children, stepchildren or legally adopted children who are unmarried, who are under 26 years of age and who qualify as legal dependents for tax exemption purposes under the United States Internal Revenue Service Tax Code. Children born to dependent children of You or Your spouse are not covered under this policy.

H. FUNCTIONING NATURAL TOOTH: means a tooth which is performing its normal role in the mastication (chewing) process in the covered person's upper or lower arch and which is opposed in the person's other arch by another tooth or prosthetic (i.e. artificial) replacement. Third molars are not considered Functioning Natural Teeth for purposes of this policy.

I. IMMEDIATE FAMILY: anyone related to You in the following manner: spouse; brother or sister (includes stepbrother and stepsister); children (includes stepchildren); parents(s) (includes stepparents); grandchildren; father- or mother-in-law;) and spouses as applicable, of any of these.

J. IN-NETWORK BENEFITS: The dental benefits provided under this Certificate for Covered Procedures that are provided by a Participating Provider.

K. NON-PARTICIPATING PROVIDER: A dentist or dental hygienist who is not a Participating Provider. These Non-Participating Providers have not entered into an agreement with us to limit their charges.

L. OUT-OF-NETWORK BENEFITS: The dental benefits provided under this Certificate for Covered Procedures that are not provided by a Participating Provider.

M. PARTICIPATING PROVIDER: A dentist or dental hygienist who has been selected by Us for inclusion in the Participating Provider Program. These Participating Providers agree to accept Our Participating Provider Maximum Allowed Charges as payment in full for services rendered. When dental care is given by Participating Providers, the Insured will generally incur less out-of-pocket cost for services rendered.

N. PARTICIPATING PROVIDER PROGRAM: Our program to offer an Insured the opportunity to receive dental care from dentists who are designated by Us as Participating Providers.

O. PATRICIPATING PROVIDER PROGRAM DIRECTORY: The list which consists of selected Participating Providers who:

1. are located in Your area; and
2. have been selected by Us to be Participating Providers and part of the Participating Provider Program.

The list will be periodically updated.

P. POLICY YEAR: Policy Year includes the First Policy Year and each subsequent Policy Year.

1. **First Policy Year:** the period of time that begins on the effective date of coverage as shown in the Policy Schedule and ends 365 days from the effective date.

2. **Each Subsequent Policy Year:** every 12-month period thereafter.

Q. POLICY YEAR DEDUCTIBLE: the amount shown in the Policy Schedule. This amount applies to each Covered Person and must be satisfied once each Policy Year before benefits are payable for Covered Dental Expenses.

R. POLICY YEAR BENEFIT MAXIMUM: the amount shown in the Policy Schedule. This amount applies to each Covered Person and is the maximum amount paid for Covered Dental Expenses per Policy Year.

S. RENEWAL DATE: is the yearly anniversary date of the policy. The first Renewal Date is 365 days from the effective date of coverage. Each subsequent Renewal Date is 365 days from the prior Renewal Date.

T. SCHEDULE AMOUNT: the amount shown in the Schedule of Covered Procedures.

U. SCHEDULE OF COVERED PROCEDURES: a listing of all Covered Dental Procedures and the corresponding Schedule Amounts.

V. TREATMENT PLAN: is the Dentist's report of recommended treatment on a form satisfactory to Us which:

a. itemizes the dental Services with ADA codes, dates of service(s) and charges required for the Necessary care of the mouth;

b. lists the charges for each Service; and

c. is accompanied by supporting pre-operative X-rays and any other appropriate diagnostic materials required by Us.

W. TYPE OF COVERAGE: (see Your Policy Schedule to determine the type of coverage in force)

X. WAITING PERIOD: the period after the effective date of coverage for which benefits are not payable. In the event of a reinstatement, all covered persons will be subject to new Waiting Periods beginning with the effective date of reinstatement. If a dependent is added by endorsement, the Waiting Period will begin from the effective date of the addition. The Waiting Period will vary based on type of service (see the Policy Schedule).

Part 2
DESCRIPTION OF BENEFITS

DENTAL BENEFITS: Subject to the Waiting Period, Policy Year Deductible, Policy Year Benefit Maximum, listed in the Policy Schedule, and Limitations and Exclusions, we will pay for services listed in the Schedule of Covered Procedures up to Covered Dental Expense amount when a charge is incurred for a Covered Dental Procedure that occurs while coverage is in force.

CHOICE OF PROVIDERS: An Covered Person may choose the services of a Participating Provider who is either a Participating Provider or a Non-Participating Provider. Benefits under this Policy are determined and payable in either case. If a Participating Provider is chosen, the Covered Person will generally incur less out-of-pocket cost.

Part 3
LIMITATIONS AND EXCLUSIONS

A. This policy does not cover losses caused by or resulting from any of the following. In addition, the procedures listed below will not be recognized toward satisfaction of any Policy Year Deductible.

1. Any procedure or service not shown on the Schedule of Covered Procedures or the Policy Schedule.
2. Amounts in excess of the Policy Year Benefit Maximum.
3. Services or supplies We consider being experimental or investigative.
4. Any injury or illness when covered under Worker's Compensation or similar law, or which is work related.
5. Services received before a Covered Person's effective date, including started but not completed services.
6. Services received after, or started but not completed within 30 days of a Covered Person's coverage ending.
7. Charges for dental services performed by other than a licensed dentist or dental hygienist.
8. Services that are not recommended by a dentist or that are not required for the preservation or restoration of oral health.
9. Repairs or adjustments to dental work within six months of the initial work.
10. Replacement prosthetics within seven years of last placement.
11. Treatment involving crowns for a given tooth within seven years of last placement, regardless of the type of crown.
12. Replacement for inlays or onlays for a given tooth within seven years of last placement.
13. Any services performed for convenience or cosmetic purposes.
14. Any charge for a service required as a result of disease or injury that is due to war or an act of war (whether declared or undeclared); taking part in an insurrection or riot; the commission or attempted commission of a crime; an intentionally self-inflicted injury or attempted suicide while sane or insane.
15. Services performed by a Dentist who is a member of the covered person's Immediate Family.
16. [Except as provided under the TMJ Expense Rider.]

B. No benefits will be paid for replacement of teeth missing prior to the effective date of coverage.
C. No benefits will be paid for the initial placement of removable full or partial dentures, unless it includes the replacement of a Functioning Natural Tooth extracted while the covered person is insured under this policy.
D. No benefits will be paid for the initial placement of a fixed partial denture including a Maryland Bridge, unless it includes the replacement of a Functioning Natural Tooth extracted while the covered person is insured under this policy.
E. Federal, State or local taxes are not included as part of a Covered Dental Expense.
F. See the Schedule of Covered Dental Procedures for all specific procedure limitations.

Part 4
INSURANCE WITH OTHER INSURERS

If there is other valid coverage, not with Us, providing benefits for the same loss on a provision of service basis or on an expense incurred basis and of which We have not been given written notice prior to the occurrence or commencement of loss, the only liability under any expense incurred coverage of this Policy will be for the proportion of the loss as the amount which would otherwise have been payable under this policy plus the total of the like amounts under all the other valid coverages for the same loss of which We had notice bears to the total like amounts under all valid coverages for the loss, and for the return of the portion of the premiums paid as shall exceed the pro-rata portion for the amount so determined. For the purpose of applying this provision when other coverage is on a provision of service basis, the "like amount" of the other coverage shall be taken as the amount that the services rendered would have cost in the absence of the coverage.

Part 5
RIGHT OF CONVERSION

If You or Your spouse dissolve Your marriage by a valid decree of dissolution of marriage and Your spouse was a Covered Person, then Your ex-spouse can apply for and receive, without evidence of insurability, a policy providing coverage not greater than the terminated coverage. To obtain the policy, Your ex-spouse must make application to Us within 60 days following the entry of the decree of dissolution of marriage. If such dissolution of marriage occurs, the Named Insured under this policy at the time of dissolution will retain that status. Any covered dependent may be covered under either policy, but not both.

Part 6
GENERAL POLICY PROVISIONS

A. ENTIRE CONTRACT; CHANGES: This policy, together with the application, endorsements, benefit agreements, riders and attached papers, if any, is the entire contract of insurance. No change in the policy is valid until approved in writing by Our president and secretary. This approval must be noted on or attached hereto. No duly licensed agent may change this policy or waive any of its provisions.

B. TIME LIMIT ON CERTAIN DEFENSES: (a) After two years from the effective date of coverage, no misstatements, except fraudulent misstatements, made by the applicant in the application will be used to void the coverage or to deny a claim for a loss incurred after the expiration of such two-year period. (b) No claim for loss incurred or disability (as defined in the Policy) commencing after two years from the date of issue of this policy will be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this Policy.

C. GRACE PERIOD: A grace period of 31 days will be granted for the payment of each premium falling after the first premium. During the grace period, this policy shall continue in force.

D. REINSTATEMENT: You may request reinstatement of Your policy directly from Us. If Your policy has lapsed for nonpayment of premium and We accept a later payment without requiring an application, Your policy will be reinstated. If We require a written application and provide You with a conditional receipt, Your policy will be reinstated upon approval of the applications from Us. If We do not notify You of Your disapproval in writing within 45 days of the date of Your application, Your policy shall be deemed reinstated. The reinstated policy shall cover loss resulting only from Covered Dental Procedures that occur after the date of reinstatement. In all other respects, You and Us shall have the same rights as provided under the policy immediately before the due date of the defaulted premium, subject to new Waiting Periods beginning with the effective date of reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period prior to the date of reinstatement.

E. NOTICE OF CLAIM: Written notice of claim must be given within 60 days after a Covered Dental Procedure starts or as soon as reasonably possible. Notice given by You or on Your behalf or on behalf of Your beneficiary to Us at [7800 Office Park Blvd, PO Drawer 14389, Baton Rouge, LA 70898-4389], or to any of Our authorized agents, with information sufficient to identify You, will be deemed notice to Us.

F. CLAIM FORMS: When We receive a notice of claim, We will send the claimant forms for filing proof of loss. If the forms are not given to You within 10 working days after the giving of such notice, You will meet the proof of loss requirements by submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

G. PROOF OF LOSS: Written proof of loss must be given to Us in case of claim for loss for which this Policy provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which We are liable, and in case of claim for any other loss within 90 days after the date of such loss. Failure to furnish such proof within the time required will not invalidate or reduce any claim if it was not reasonably possible to give proof within such time. However, such proof must be furnished as soon as reasonably possible and in no event (except in the absence of legal capacity) later than 12 months from the time of proof is otherwise required.

H. TIME OF PAYMENT OF CLAIMS: benefits payable under this policy will be paid immediately upon Our receipt of written proof of loss.

I. PAYMENT OF CLAIMS: All benefits will be payable to You unless assigned by You or by operation of law. Any accrued benefits unpaid at Your death will be paid to Your estate.

J. **CLAIMS REVIEW PROCEDURE:** If a claim is denied in whole or in part, You may request a review of the claim. The request must be in writing and must be made within 6 months after the claim was denied. Send the request to Us at P.O. Box 98100, Baton Rouge, LA 70898-9100. The request should contain any facts that the Insured considers important to the review. We will review the claims decision and send a response in writing within thirty (30) days. If the denial of benefits is confirmed, You will be told the reasons for the decision.

K. LEGAL ACTIONS: No legal action may be brought to recover on this policy within 60 days after written proof of loss has been given as required. No such action may be brought after six years from the time written proof of loss is required to be given.

L. CONFORMITY WITH STATE AND FEDERAL STATUTES: Any provisions of this policy that on its effective date is in conflict with the statutes of the state in which it was issue or with any federal statutes is hereby amended to conform to the minimum requirements of such statutes.

M. OTHER INSURANCE WITH THIS INSURER: If any person is covered under more than one policy or rider from Us, only the one chosen by You, Your beneficiary or Your estate, as the case may be, will be effective. We will return all premiums paid for that person for all other dental coverage from the date of duplication.

N. PRE-ESTIMATION OF BENEFITS: Whenever the estimated cost of a recommended dental Treatment Plan exceeds $300, the Treatment Plan may be submitted to Us for review before treatment begins. The Treatment Plan should be accompanied by supporting pre-operative X-rays and any other appropriate diagnostic materials that We or Our dental consultants request. We will notify the covered person and the attending Dentist of the estimated benefits payable based upon the Treatment Plan. In determining the amount of benefits payable, consideration will be given to alternate procedures that may accomplish a professionally satisfactory result. If the covered person and His Dentist decide on a more expensive method of treatment than that pre-estimated by Us, benefits will be paid for the more costly treatment, but only up to the Policy liability for the less expensive alternate Service. We will not pay the excess amount. Since this may result in significant out-of-pocket expense, We strongly encourage You to follow the pre-estimation procedure for any Treatment Plan which will exceed $300 in cost. Pre-Estimation of Benefits is not a promise of payment.

O. **SERVICES PERFORMED OUTSIDE THE U.S.A.:** Any Claim submitted for procedures outside the U.S.A. must: (1) be for a Covered Procedure, as defined; (2) be supplied in English; (3) use American Dental Association (ADA) codes; and (4) be in U.S. Dollar currency. Reimbursement will be based on the applicable Scheduled Fee amounts.

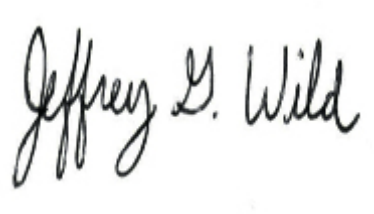
P. **UNEARNED PREMIUMS:** Upon the death of the policyholder, the premiums paid for coverage for the any period beyond the end of the policy month in which the death occurred shall be returned. The unearned premiums shall be returned no later than 30 days after the company has received proof of death of the policyholder.

Q. **RECOVERY OF OVERPAYMENTS:** We reserve the right to deduct from any benefits properly payable under this Policy the amount of any payment that has been made:

1. In error; or
2. pursuant to a misstatement contained in a proof of loss; or
3. pursuant to fraud or misrepresentation made to obtain coverage under this Policy within two (2) years after the date such coverage commences; or
4. with respect to an ineligible person; or
5. pursuant to a claim for which benefits are recoverable under any Policy or act of law providing coverage for occupational injury or disease to the extent that such benefits are recovered.

Such deduction may be against any future claim for benefits under the Policy made by a Covered Person if claim payments previously were made with respect to a Covered Person.

IN WITNESS WHEREOF, We have caused this Policy to be signed by Our President and Secretary.



Secretary

President

Countersigned by: _____

(A licensed resident agent where required by law)

Starmount Life Insurance Company

[Home Office: 7800 Office Park Blvd., PO Box 98100, Baton Rouge, LA 70898-9100
Administrative Office: AlwaysCare Benefits, Inc., 7800 Office Park Blvd, PO Drawer 14389
Baton Rouge, LA 70898-4389]
Toll Free Telephone No: 1-888-729-5433

VISION BENEFITS RIDER

This Rider is attached to and made a part of the Policy and is subject to all policy provisions unless modified herein.

We have issued this Rider because:

a. the premium for this Rider is included in the premium due under the policy.

VISION BENEFITS DEFINITIONS

CO-PAY: A Covered Person's share of the costs for Covered Services or Materials that are provided by a Participating Provider. The Co-Pay is paid directly to the Participating Provider at the time services are rendered. If a Non-Participating Provider is used, the Co-Pay will be deducted from the Out-of-Network Allowance at the time We pay benefits. Co-Pay amounts and allowances are listed in the Policy Schedule.

CONTACT LENSES, ELECTIVE: – Elective contact lenses refer to contact lenses an Insured chooses to wear instead of eyeglasses for reasons of comfort or appearance.

CONTACT LENSES, NON ELECTIVE; Non-elective Contact Lenses refer to contact lenses that are prescribed solely for the purpose of correcting one of the following medical conditions. These conditions prevent the Covered Person from achieving a specified level of visual acuity (performance) through the wearing of conventional eyeglasses.

1. Aphakia (after cataract surgery). A pair of prescription single vision or multifocal eyeglass lenses and an eye frame can be provided in addition to Non-Elective Contact Lenses for this condition.
2. When visual acuity cannot be corrected to 20/70 in the better eye except through the use of Contact Lenses (must be 20/60 or better).
3. Anisometropia of 4.0 diopters or more, provided visual acuity improves to 20/60 or better in the weak eye.
4. Keratoconus.

Reimbursement of Non-Elective Contact Lenses will be considered as payment in-full if utilizing the services of a Participating Provider.

COVERED SERVICES OR MATERIALS: – Means the Vision Exam services and Materials that qualify for benefits under this Policy. Covered Services or Materials are shown in the Policy Schedule.

EYEGLASS LENSES: A standard glass or plastic (CR39) lens, which is optically clear, that will fit an eye glass frame with a lens size less than 61mm in length. Standard multifocal lenses include segments through flat top 35 for plastic bifocal and lenticular lenses, through flat top 28 for glass trifocals, and through flat top 35 for plastic trifocals.

MATERIALS: Means corrective Eyeglass Lenses, Frames and Contact Lenses.

PLANO LENS: A lens that has no refractive power.

ROLLING BENEFIT PLAN: Benefits begin anew 12 OR 24 months from the date of service.

SCHEDULE AMOUNT: The amount shown in the Policy Schedule.

POLICY SCHEDULE: A listing of all Covered Vision Procedures and the corresponding Schedule Amounts.

VISION EXAM: An examination of principal vision functions. A Vision Exam includes, but is not limited to, case

history, examination for pathology or anomalies, job visual analysis, refraction, visual field testing and tonometry, if indicated. The exam must be consistent with the community standards, rules and regulations of the jurisdiction in which the provider's practice is located.

YOU OR YOUR: The Policyholder.

TERMINATION – This rider will terminate if the Policy to which it is attached terminates, when the maximum benefit has been paid to all covered dependent children, when all dependent children have attained age 19, or if the premium for this rider is not paid.

SCHEDULE OF COVERED VISION SERVICES & MATERIALS

The following is a complete summary of Covered Vision Services and Materials. We will not pay benefits for expenses incurred for any Procedure not listed in this Schedule of Covered Vision Services and Materials. We reserve the right to amend, change or modify any part of this Schedule at the beginning of any Policy Year upon 60 days written notice to the Policyholder and such amendments, changes or modifications shall be effective on the date specified in such notice.

DESCRIPTION OF VISION BENEFITS

[Vision Examination Benefit:

If a Covered Person incurs expenses for a Vision Examination, We will pay such expenses up to the applicable Vision Examination Benefit shown in the Policy Schedule, subject to the Limitations and Exclusions of this Policy.]

[We pay a benefit if a Covered Person receives Covered Services or Materials at the allowable Frequency while his coverage under this Policy is in force. A Covered Person may choose to receive vision care services from either a Participating Provider or a Non-Participating Provider. If a Participating Provider is chosen, the Covered Person will generally incur less out-of-pocket cost.]

A. In-Network Benefits

When You enroll for coverage, a Participating Provider Directory will be made available to You with the names, phone numbers and addresses of Participating Providers. A provider's status may occasionally change. We recommend that You call the Administrator to verify the provider's participation status in the network. You may change providers at any time without notice to the Administrator.

When benefits are payable for Covered Services or Materials received from a Participating Provider, we will pay the Participating Provider directly, based on the In-Network benefits shown in the Policy Schedule. The Covered Person pays any required Co-Pay and any charges above the covered benefits to the Participating Provider. The Participating Provider takes care of claims submission and administrative services.

Note Exception: If you use the services of a Participating Provider but take advantage of a sale, coupon, or other in-store special, the Participating Provider may require that you pay in full and submit Your receipt for reimbursement at the Out-of-Network reimbursement.

Both the Co-Pay and the Frequency for Covered Services or Materials are shown in the Policy Schedule.

B. Out-of-Network Benefits

If an Covered Person chooses to use a Non-Participating Provider, You must pay the provider in full for the services and materials purchased. It is your responsibility to send us a Claim by submitting the itemized invoice or receipt to us. (See the "Notice of Claim" provision.) Any Co-Pay that applies should not be paid to the Non-Participating Providers, as it will be deducted by Us at the time the claim is processed.

When benefits are payable for Covered Services or Materials received from a Non-Participating Provider, We will reimburse you up to the amount of Out-of-Network benefits shown in the Policy Schedule, less any Co-Pay.

C. Covered Services or Materials

Covered Services or Materials are shown in the Policy Schedule. In order to be a Covered Service or Material, the services or materials must be furnished to a Covered Person:

1. To check or improve their vision condition;
2. Within the allowable Frequency shown in the Policy Schedule;
3. By an Ophthalmologist, Optometrist or Optician, regardless of whether such provider is a Participating or a Non-Participating Provider.

In no event will coverage exceed the lesser of:

1. the actual cost incurred of the Covered Services or Materials; or
2. the limits of coverage shown in the Policy Schedule.

VISION POLICY LIMITATIONS & EXCLUSIONS

The Contact Lenses benefit is paid in lieu of Eyeglass Lenses and Frames. A Covered Person is eligible to receive benefits under the Eyeglass Lenses Benefit or the Frame benefit only after the Contact Lenses benefit Frequency has ended.

The Eyeglass Lenses benefit and the Eyeglass Frame benefit is paid in lieu of the Contact Lenses benefit. A Covered Person is eligible to receive benefits under the Contact Lenses benefit only after the Eyeglass Lenses benefit Frequency has ended.

Dilation is covered in full under the Vision Exam benefit ONLY if done for one of the following conditions: central vision loss, photopsia, floaters, high myopia, diabetes or history of ocular surgery, ocular trauma or ocular disease .

Exclusions

No benefits are payable for the any of the following conditions, procedures and/or materials, unless otherwise specifically listed as a covered benefit in the Policy Schedule:

1. Replacement frames and/or lenses, except at normal intervals when covered services are otherwise available;
2. Plano or non-prescription lenses or sunglasses;
3. Orthoptics, vision training and any associated supplemental testing;
4. Frame cases;
5. Low (subnormal) vision aids or aniseikonic lenses;
6. Medical and surgical treatment of the eyes;
7. Charges incurred after (a) the Policy ends; or (b) the Insured's coverage under the Policy ends, except as stated in the Policy;
8. Experimental or non-conventional treatment or device;
9. Any eye examination or corrective eyewear required by an Employer as a condition of employment;
10. Services and materials provided by another vision plan except in the case of Coordination of Benefits;
11. Services for which benefits are paid by Worker's Compensation;
12. Benefits provided under the employee's medical insurance except in the case of Coordination of Benefits;
13. Blended bifocal lenses
14. Groove, Drill or Notch, and Roll and Polish;
15. Two pairs of glasses, in lieu of bifocals, trifocals or progressives;
16. Coating on lenses (Factory scratch coat, anti-reflective, sunglass colors, etc.)
17. Cosmetic items;
13. Faceted lenses
14. High-Index Lenses
15. Laminated Lenses
16. Oversize Lenses – any lens with an eye size of 61mm or greater
17. Photochromic (Transition) lenses
18. Polaroid lenses
19. Polished bevel lenses
20. Polycarbonate lenses

21. Prism lenses
22. Slab-off lenses
23. Tints
24. Ultra-violet tint or coating
25. Additional cost for contact lenses over the allowance
26. Additional cost for a frame over the allowance
27. Regardless of optical necessity, the Vision Examination Benefit in not available more frequently than specified in the Schedule of Benefits.
28. Services received before Your effective date, including started but not completed services.
29. Charges for services rendered by a provider other than Ophthalmologist or Optometrist acting within the scope of his or her license.
30. Treatment or services received while outside the territorial limits of the United States.
31. Any charge for a service required as a result of disease or injury that is due to war or an act of war (whether declared or undeclared); taking part in an insurrection or riot; the commission or attempted commission of a crime; an intentionally self-inflicted injury or attempted suicide while sane or insane.
32. Federal, State or local taxes
33. Progressive Power Lenses*

*Progressive Power Lens Benefit. If this type of lens is not a covered benefit under your Certificate, the Provider will apply the retail charge for standard trifocal lenses against the charge for the style of progressive lens You have selected. You pay the Provider the difference, if any, between the two.

VISION RIDER CLAIM PROVISIONS

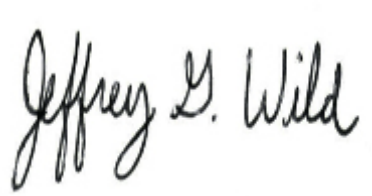
A. In-Network Claims

When a Covered Person receives services from a Participating Provider, the provider will handle all claims and administrative services for You. Participating Providers submit charges directly to the Administrator. (Note the exception under "Description of Vision Benefits")

B. Out-of-Network Claims

In order to pay benefits for Covered Services or Materials provided by a Non-Participating Provider, You must furnish written proof of loss. Your Claim must be sufficient to identify the Covered Person, and the name of the Policyholder. Claim forms are available through the Administrator, or You may submit itemized receipts for services.

In Witness whereof, Our president and secretary signed this rider as of the effective date shown on the Policy Schedule of Benefits.



Secretary

President

Starmount Life Insurance Company

[Home Office: 7800 Office Park Blvd., P.O. Box 98100, Baton Rouge, LA 70898-9100
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Toll Free Telephone No: 1-888-729-5433

TEMPOROMANDIBULAR JOINT (TMJ) TREATMENT RIDER

This Rider is attached to and made a part of the Policy and is subject to all policy provisions unless modified herein. We have issued this Rider because:

a. the premium for this Rider is included in the premium due under the Policy.

DEFINITIONS

COVERED TMJ PROCEDURES means only the procedures listed in the Schedule of Covered TMJ Procedures.

LIFETIME MAXIMUM means the maximum benefit payable by Us under the provisions of this Rider for Covered TMJ Procedures in a Covered Person's lifetime. All benefits paid for a Covered Person's Covered TMJ Procedures will be applied to the Lifetime Maximum even when coverage was interrupted. The Lifetime Maximum for each Covered Person is shown in the TMJ section of the Policy Schedule.

TEMPOROMANDIBULAR JOINT (TMJ) SYNDROME means a disorder that is caused by faulty articulation of the temporomandibular joint and is characterized by facial pain, headache, ringing ears, dizziness and stiffness of the neck.

TMJ TREATMENT means the treatment of TMJ Syndrome by a Dentist.

TREATMENT PLAN means the Dentist's report of recommended TMJ Treatment on a form satisfactory to Us which:

a. is accompanied by:
    1. X-rays of temporomandibular joints and skull;
    2. X-rays of dentition;
    3. Copy of comprehensive history and clinical evaluation; and
b. specifies:
    1. Each phase of treatment and the time period for each phase of treatment;
    2. Type of treatment to be provided for each phase;
    3. Total length of treatment for all phases combined;
    4. Breakdown of charges for each phase of treatment;
    5. Total charges for all phases of treatment.

WAITING PERIOD means the period of time a Covered Person must wait before being eligible for benefits under this Rider. The Waiting Period for TMJ benefits is shown on the Policy Schedule of Benefits. If TMJ treatment is started before coverage under this Rider begins, including during the Waiting Period, then the entire TMJ Treatment Plan will be ineligible for benefits.

BENEFITS PAYABLE

This Rider provides benefits for the treatment of TMJ Syndrome. It only provides benefits for Covered TMJ Procedures. Benefits are subject to:

a. Our receipt of a Treatment Plan from the Dentist providing the TMJ Treatment;
b. Satisfaction of any required Waiting Period;
c. The Lifetime Maximum for each Covered Person.

PAYMENT OF BENEFITS

The amount of the benefit payable is shown in the Schedule of Covered TMJ Procedures below. The benefits payable for all Covered TMJ Procedures on the same Treatment Plan will be paid in equal quarterly (i.e., 3 month periods) installments.

The benefit payment schedule for TMJ Treatment will be determined by:

a. Calculating the total benefit payable for the Covered TMJ Procedures; and
b. Dividing the total benefit payable by the number of quarters that TMJ Treatment is expected to last to determine the amount that will be paid for each quarter commencing on the date TMJ Treatment starts.

The initial payment will be payable as of the date TMJ Treatment is started. The subsequent quarterly benefit payments will be made every three months after the date that the TMJ Treatment is started and for as long as the insurance remains in force, until the end of the Treatment Plan period or 24 months, whichever comes first.

TERMINATION

This rider will terminate on the earlier of:

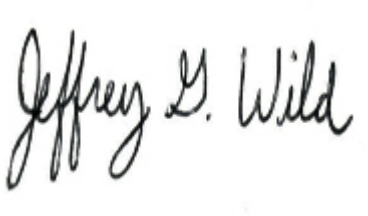
a. The date the Policy to which it is attached terminates;
b. The date the Lifetime Maximum benefit has been paid to all Covered Persons under the policy.

SCHEDULE OF COVERED TMJ PROCEDURES

The following is a complete list of Covered TMJ Procedures. We will not pay benefits for expenses incurred for any Procedure not listed in this Schedule of Covered TMJ Procedures. We reserve the right to amend, change or modify any part of this Schedule at the beginning of any Policy Year upon 60 days written notice to You. Such amendments, changes or modifications shall be effective on the date specified in such notice.

Procedure Code	Description	Schedule Amount
D0320	TM Arthogram, Including Injection	90
D7820	Closed Reduction of Dislocation	81
D7870	Arthocentesis	52
D7880	Occlusal Orthotic Device, by report	107

In Witness whereof, Our President and Secretary signed this rider as of the effective date shown on the Policy Schedule.



Secretary

President

SCHEDULE OF COVERED DENTAL PROCEDURES

SUBJECT TO THE WAITING PERIOD, POLICY YEAR DEDUCTIBLE, POLICY YEAR BENEFIT MAXIMUM, PERCENTAGE OF COVERED DENTAL EXPENSES LISTED IN THE POLICY SCHEDULE, AND THE LIMITATIONS AND EXCLUSIONS SECTION OF THE POLICY, WE WILL PAY THE FOLLOWING BENEFITS UP TO THE COVERED DENTAL EXPENSE AMOUNT WHEN A CHARGE IS INCURRED FOR A COVERED DENTAL PROCEDURE THAT OCCURS WHILE COVERAGE IS IN FORCE.

The following is a complete list of Covered Dental Procedures, applicable limitations, and Scheduled Amounts. We will not pay benefits for expenses incurred for any Procedure not listed in the Schedule of Covered Procedures.

¶ Limitations

(a) Maximum of 1 procedure per 6 months
(b) Maximum of 1 procedure per 36 months
(c) Limited to Dependent Children under age 19
(d) Maximum of 1 procedure per 12 months
(e) Maximum of 1 procedure per 12 months per provider
(f) Maximum of 1 procedure per 24 months
(g) Applications made to permanent molar teeth only
(h) Maximum of 2 procedures per arch per 24 months
(i) Maximum of 1 per 5 year period per tooth
(j) Maximum of 1 each quadrant per 12 months
(k) Maximum of 1 each quadrant per 36 months
(l) Maximum of 1 per tooth surface per tooth
(m) Subject to a yearly and lifetime maximum
(n) Maximum of 2 procedures per 12 months
(o) Replacement of existing only if in place for 36 months (for insureds over age 19) and in place for 12 months (for insureds under age 19)
(p) Not in conjunction with TMJ
(q) Benefits based on the benefit for the corresponding non-cosmetic restoration on posterior teeth.
(r) Maximum 1 time per tooth or site
(s) Maximum of 1 per lifetime
(t) Only in conjunction with listed complex oral surgery procedures and subject to review
(u) Limited to 2 oral evaluation procedures, in any combination (D0120, D0140, D0145,D0150, D0170, per 12 month period
(v) Limited to 1 bitewing x-ray procedure (D0270, D0272, D0273, D0274) up to 4 films per 12 month period
(w) Limited to dependent children under age 16
(x) Limited to patients age 25 and older
(y) 6 months must have passed since initial placement
(z) Maximum of 1 per 7 year period when existing appliance / restoration is not serviceable.
(aa) Maximum of 1 per lifetime, per quadrant or arch
(bb) Maximum of 1 per 5 year period
(cc) Limited to patients age 16 and over
(dd) X-rays and pathology report required
(ee) Limited to 1 x-ray procedure (D0210, D0277, D0330) per 5 year period
(ff) Only for those age 40 and over who demonstrate risk factors for oral cancer and/or a suspicious lesion
(gg) not in conjunction when a completed root canal is performed by the same provider)
(hh) limited to once per site per year
(ii) premolar teeth only
(jj) maximum of 3 per quadrant in a 3 year period to address periodontal disease only
(kk) involving a minimum of 2 lower or 3 total impactions or by report. Subject to review and up to a total 1 hour maximum
(ll) maximum of 3 teeth per quadrant and after the appropriate timeframe past D4341 with pocket depths of 5-7 mm. Benefit deducted from surgery benefit in the event surgery is needed within 1 year.
(mm) In lieu of an approvable fixed bridge for a 1 tooth replacement

Procedure	Description	Limitations	Value Plan Schedule Amount	Standard Plan Schedule Amount	Preferred Plan Schedule Amount
D0120	Periodic Oral Evaluation	[(u)]	19	27	35
D0140	Limited Oral Evaluation - Problem Focused	[(u)]	29	41	53
D0145	Oral Evaluation – Patient under 3-yrs of Age	[(u)]	26	37	48
D0150	Comprehensive Oral Evaluation	[(u)]	31	44	57
D0170	Re-evaluation - Limited-Problem Focused (not post-op visit) (benefited for accidental injury monitoring only)	[(u)]	24	35	45
D0180	Comprehensive periodontal evaluation - new or established patient	[(e)]	41	58	75

D0210	Intraoral - Complete Series - FMX (including Bitewings)	[(ff)]	53	75	98
D0220	Intraoral - Periapical First Film		11	16	20
D0230	Intraoral - Periapical Each additional Film (6 or more is considered FMX)		9	13	17
D0240	Intraoral - Occlusal Film		15	22	28
D0250	Extraoral – First Film (by report)		22	31	40
D0260	Extraoral – Each Additional Film (by report)		19	27	35
D0270	Bitewing - Single Film	[(v)]	11	16	20
D0272	Bitewings – Two Films	[(v)]	17	24	31
D0273	Bitewings – Three Films	[(v)]	21	29	38
D0274	Bitewings - Four Films	[(v)]	25	35	46
D0277	Vertical Bitewings - Seven to Eight Films	[(ff)]	37	52	68
D0330	Panoramic Film	[(ff)]	43	61	79
D0431	Adjunctive Pre-diagnostic test aiding in the detection of muscosal abnormalities	[(d), (gg)]	21	30	39
D0472	Accession of Tissue, Gross Exam including report	[(ii)]	31	44	57
D0473	Accession of Tissue, Gross and Micro Exam including report	[(ii)]	70	99	128
D0474	Accession of Tissue, Gross and Micro Exam (including assessment of . surgical margins) including report	[(ii)]	114	161	209
D0486	Accession of brush biopsy sample, microscopic examination, preparation and transmission of written report	[(d), (gg)]	66	94	121
D1110	Prophylaxis – Adult (age 14 and above)	[(n)]	36	52	67
D1120	Prophylaxis - Child	[(n)]	26	37	48
D1203	Topical Application of Fluoride (Prophylaxis not included) - Child	[(w) (d)]	14	20	26
D1206	Topical fluoride varnish, therapeutic application of moderate to high caries risk patients	(d)]	15	21	27
D1351	Sealant - per tooth	[(b) (w) (g)]	21	30	39
D1510	Space Maintainer - Fixed - Unilateral	[(w) (bb)]	132	187	242
D1515	Space Maintainer - Fixed - Bilateral	[(w) (bb)]	197	279	361
D1520	Space Maintainer - Removable - Unilateral	[(w) (bb)]	158	224	290
D1525	Space Maintainer - Removable - Bilateral	[(w) (bb)]	234	332	429
D1550	Recementation of Space Maintainer (per Space Maintainer)	[(w) (bb) (z)]	28	39	51
D1555	Removal of fixed space maintainer	[(w) (bb)]	28	39	51
D2140	Amalgam - One surface, primary or permanent	[(o) (l)]	39	56	72
D2150	Amalgam – Two surfaces, primary or permanent	[(o) (l)]	48	68	88
D2160	Amalgam - Three surfaces, primary or permanent	[(o) (l)]	58	82	106
D2161	Amalgam – Four or more surfaces, primary or permanent	[(o) (l)]	68	96	125
D2330	Resin - One surface, Anterior	[(o) (l)]	45	64	83
D2331	Resin - Two surfaces, Anterior	[(o) (l)]	55	79	102
D2332	Resin - Three surfaces, Anterior	[(o) (l)]	67	95	123
D2335	Resin - Four or more surfaces or involving incisal angle (Anterior)	[(o) (l)]	81	114	148
D2390	Resin-based composite crown, anterior	[(o) (l) (q)]	98	139	180
D2391	Resin-based composite - one surface, posterior	[(o) (l) (q)]	50	71	92
D2392	Resin-based composite - two surfaces, posterior	[(o) (l) (q)]	66	93	120
D2393	Resin-based composite - three surfaces, posterior	[(o) (l) (q)]	80	114	147
D2394	Resin-Based composite - four or more surfaces, posterior	[(o) (l) (q)]	90	128	165
D2510	Inlay - Metallic - One surface	[(aa) (dd)]	90	128	165
D2520	Inlay - Metallic - Two surfaces	[(aa) (dd)]	122	172	223
D2530	Inlay - Metallic - Three or more surfaces	[(aa) (dd)]	152	215	279
D2542	Onlay-Metallic-Two Surfaces	[(aa) (dd)]	163	231	299
D2543	Onlay-Metallic-Three surfaces	[(aa) (dd)]	171	242	314
D2544	Onlay-Metallic-Four or more surfaces	[(aa) (dd)]	177	251	325
D2610	Inlay – Porcelain/Ceramic - One surface	[(aa) (dd) (q)]	126	179	231
D2620	Inlay – Porcelain/Ceramic - Two surfaces	[(aa) (dd) (q)]	148	210	272
D2630	Inlay – Porcelain/Ceramic - Three or more surfaces	[(aa) (dd) (q)]	158	224	290
D2642	Onlay - Porcelain/Ceramic - Two surfaces	[(aa) (dd) (q)]	168	238	309
D2643	Onlay - Porcelain/Ceramic - Three surfaces	[(aa) (dd) (q)]	171	242	314

D2644	Onlay - Porcelain/Ceramic - Four or more surfaces	[(aa) (dd) (q)]	177	251	325
D2650	Inlay - Resin-Based Composite - One surface	[(aa) (dd) (q)]	68	96	124
D2651	Inlay - Resin-Based Composite - Two surfaces	[(aa) (dd) (q)]	117	166	215
D2652	Inlay - Resin-Based Composite - Three or more surfaces	[(aa) (dd) (q)]	126	179	231
D2662	Onlay - Resin-Based Composite - Two surfaces	[(aa) (dd) (q)]	132	187	243
D2663	Onlay - Resin-Based Composite - Three surfaces	[(aa) (dd) (q)]	153	217	281
D2664	Onlay - Resin-Based Composite - Four or more surfaces	[(aa) (dd) (q)]	158	223	289
D2710	Crown - Resin (Indirect)	[(aa) (dd) (q)]	65	92	119
D2720	Crown - Resin with High Noble Metal	[(aa) (dd) (q)]	167	236	305
D2721	Crown - Resin with Predominantly Base Metal	[(aa) (dd) (q)]	135	192	248
D2722	Crown - Resin with Noble Metal	[(aa) (dd) (q)]	135	191	248
D2740	Crown - Porcelain/Ceramic Substrate	[(aa) (dd) (q)]	178	252	326
D2750	Crown - Porcelain Fused to High Noble Metal	[(aa) (dd) (q)]	167	237	306
D2751	Crown - Porcelain Fused to Predominantly Base Metal	[(aa) (dd) (q)]	149	211	274
D2752	Crown - Porcelain Fused to Noble Metal	[(aa) (dd) (q)]	158	223	289
D2780	Crown-3/4 Cast High Noble metal	[(aa) (dd) (q)]	176	249	322
D2781	Crown - 3/4 Cast High predominantly Base Metal	[(aa) (dd)]	54	77	99
D2782	Crown - 3/4 Cast Noble Metal	[(aa) (dd) (q)]	171	242	314
D2783	Crown - 3/4 Cast Porcelain/Ceramic	[(aa) (dd) (q)]	177	250	324
D2790	Crown - Full Cast High Noble Metal	[(aa) (dd)]	163	231	299
D2791	Crown - Full Cast Predominantly Base Metal	[(aa) (dd)]	158	223	289
D2792	Crown - Full Cast Noble Metal	[(aa) (dd)]	166	235	304
D2910	Recement Inlay	[(z)]	15	22	28
D2920	Recement Crown	[(z)]	15	21	27
D2930	Prefabricated Stainless Steel Crown - Primary tooth	[(aa) (w)]	39	55	71
D2931	Prefabricated Stainless Steel Crown - Permanent tooth	[(aa) (w)]	44	62	80
D2932	Prefabricated Resin Crown	[(aa) (w)]	46	65	83
D2950	Core Buildup, including any pins	[(aa)]	39	56	72
D2951	Pin Retention - per tooth, in addition to restoration	[(aa)]	7	10	13
D2952	Cast Post and Core in addition to Crown	[(aa)]	59	83	108
D2954	Prefabricated Post and Core in addition to Crown	[(aa)]	50	70	91
D2980	Crown repair, by report	[(aa) (dd)]	33	47	91
D3220	Therapeutic Pulpotomy (excluding final restoration)	[(r) (hh)]	26	37	48
D3221	Gross Pulpal Debridement, Primary and Permanent	[(r) (hh)]	28	39	50
D3230	Pulpal Therapy (Resorbable Filling) - Anterior, Primary tooth (excluding final rest	[(r)]	36	51	66
D3240	Pulpal Therapy (Resorbable Filling) - Posterior, Primary tooth (excluding final rest	[(r)]	37	52	68
D3310	Anterior (excluding final restoration)	[(r)]	114	162	209
D3320	Bicuspid (excluding final restoration)	[(r)]	134	190	247
D3330	Molar (excluding final restoration)	[(r)]	171	242	313
D3332	Incomplete Endodontic Therapy (inoperable or fractured tooth)	[(r)]	59	83	107
D3333	Internal Root Repair of Perforation Defects	[(r)]	45	64	83
D3346	Retreatment of previous Root Canal Therapy – Anterior (at least 6 months after previous root Canal Therapy)	[(r)]	131	186	241
D3347	Retreatment of previous Root Canal Therapy – Bicuspid (at least 6 months after previous root Canal Therapy)	[(r)]	151	214	278
D3348	Retreatment of previous Root Canal Therapy – Molar (at least 6 months after previous root Canal Therapy)	[(r)]	188	266	344
D3351	Apexification/Recalcification - Initial Visit (apical closure/calcific repair of perforations, root resorption, etc.)	[r]	50	70	91
D3352	Apexification/Recalcification - interim medication replacement	[r]	29	41	53
D3353	Apexification/Recalcification - Final Visit (includes completed root canal therapy)	[r]	81	115	149
D3410	Apicoectomy/Periradicular Surgery - Anterior	[r]	133	189	245
D3421	Apicoectomy/Periradicular Surgery - Bicuspid (first root)	[r]	144	204	264

D3425	Apicoectomy/Periradicular Surgery - Molar (first root)	[r]	158	223	289
D3426	Apicoectomy/Periradicular Surgery (each additional root)	[r]	50	70	91
D3430	Retrograde Filling - per root	[r]	36	51	66
D3450	Root Amputation - per root	[r]	81	115	149
D3920	Hemisection (including any root removal), not including Root Canal Therapy	[(s)]	59	83	108
D4210	Gingivectomy or Gingivoplasty - per quadrant	[(k)]	89	125	162
D4211	Gingivectomy or Gingivoplasty, per tooth	[(k)]	35	49	64
D4240	Gingival Flap Procedure, including Root Planing - per quadrant	[(k)]	113	159	206
D4241	Gingival Flap Procedure, including Root Planing - one to three teeth per quadrant	[(k)]	83	117	151
D4249	Clinical Crown Lengthening - Hard Tissue	[(r)]	135	191	248
D4260	Osseous Surgery (including Flap Entry and Closure) - per quadrant	[(k)]	170	241	312
D4261	Osseous Surgery (including Flap Entry and Closure) - one to three teeth, per quadrant	[(k)]	149	211	273
D4263	Bone Replacement Graft - first site in quadrant	[(r)]	72	102	132
D4264	Bone Replacement Graft - each additional site in quadrant	[(r))]	45	64	83
D4265	Biologic materials to aid in soft and osseous tissue regeneration	[(r)]	66	93	120
D4270	Pedicle Soft Tissue Graft Procedure	[(k)	137	194	251
D4271	Free Soft Tissue Graft Procedure (including Donor Site Surgery)	[(k)]	149	210	272
D4273	Subepithelial Connective Tissue Graft Procedure (including Donor Site Surgery)	[(k)]	171	242	314
D4274	Distal or Proximal Wedge Procedure (when not performed in conjunction with Surgical procedures in the same area)	[(k)]	81	115	149
D4275	Soft tissue allograft	[(k)]	140	198	256
D4276	Combined connective tissue and double pedicle graft	[(k)]	176	249	322
D4341	Periodontal Scaling and Root Planing, per quadrant	[(k)]	38	54	70
D4342	Periodontal Scaling and Root Planing - one to three teeth, per quadrant	[(k)]	25	36	46
D4381	Localized delivery of chemo agents	[(k) (mm)]	9	12	16
D4910	Periodontal Maintenance Procedures (following active therapy and in lieu of a D1110)	[(n)]	22	31	40
D5110	Complete Denture - Maxillary	[(aa)]	189	268	347
D5120	Complete Denture - Mandibular	[(aa)]	189	268	347
D5130	Immediate Denture - Maxillary	[(aa)]	210	297	384
D5140	Immediate Denture - Mandibular	[(aa)]	210	297	384
D5211	Maxillary Partial Denture - Resin Base (including any conventional clasps, rests and teeth)	[(aa)]	150	213	276
D5212	Mandibular Partial Denture - Resin Base (including any conventional clasps,rests and teeth)	[(aa)]	166	235	304
D5213	Maxillary Partial Denture - Cast Metal Framework with Resin Denture Bases (inclu	[(aa)]	214	303	393
D5214	Mandibular Partial Denture - Cast Metal Framework with Resin Denture Bases (incl	[(aa)]	214	303	393
D5281	Removable Unilateral Partial Denture - One piece cast Metal (including clasps and teeth)	[(aa)]	122	172	223
D5410	Adjust Complete Denture - Maxillary	[(d) (z)]	12	17	21
D5411	Adjust Complete Denture - Mandibular	[(d) (z)]	12	17	21
D5421	Adjust Partial Denture - Maxillary	[(d) (z)]	12	17	22
D5422	Adjust Partial Denture - Mandibular	[(d) (z)]	12	17	21
D5510	Repair broken Complete Denture Base	[(d) (z)]	27	38	49
D5520	Replace missing or broken teeth - Complete Denture (each tooth)	[(d) (z)]	23	32	41
D5610	Repair Resin Denture Base	[(d) (z)]	26	37	48
D5620	Repair Cast Framework	[(d) (z)]	32	45	58
D5630	Repair or Replace Broken Clasp	[(d) (z)]	32	45	58
D5640	Replace broken teeth - per tooth	[(d) (z)]	23	33	43
D5650	Add tooth to existing Partial Denture	[(d) (z)]	28	40	51

D5660	Add Clasp to existing Partial Denture	[(d) (z)]	32	46	59
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	[(aa)]	86	121	157
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	[(aa)]	90	128	165
D5710	Rebase Complete Maxillary Denture	[(f) (z)]	72	102	132
D5711	Rebase Complete Mandibular Denture	[(f) (z)]	72	102	132
D5720	Rebase Maxillary Partial Denture	[(f) (z)]	72	102	132
D5721	Rebase Mandibular Partial Denture	[(f) (z)]	72	102	132
D5730	Reline Complete Maxillary Denture (chair side)	[(f) (z)]	48	68	87
D5731	Reline Complete Mandibular Denture (chair side)	[(f) (z)]	46	65	84
D5740	Reline Maxillary Partial Denture (chair side)	[(f) (z)]	45	64	83
D5741	Reline mandibular Partial Denture (chair side)	[(f) (z)]	45	64	83
D5750	Reline Complete Maxillary Denture (laboratory)	[(f) (z)]	63	89	116
D5751	Reline Complete Mandibular Denture (laboratory)	[(f) (z)]	63	89	116
D5760	Reline Maxillary Partial Denture (laboratory)	[(f) (z)]	63	89	116
D5761	Reline Mandibular Partial Denture (laboratory)	[(f) (z)]	63	89	116
D5810	Interim complete denture (maxillary)	[(s)]	99	140	182
D5811	Interim complete denture (mandibular)	[(s)]	101	144	186
D5820	Interim partial denture (maxillary)	[(s)]	82	116	150
D5821	Interim partial denture (mandibular)	[(s)]	87	124	160
D5850	Tissue Conditioning, Maxillary	[(f) (z)]	23	32	41
D5851	Tissue Conditioning, Mandibular	[(f) (z)]	23	32	41
D6058	Abutment supported porcelain/ceramic crown	[(aa) (dd) (nn) (q)]	223	315	408
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	[(aa) (dd) (nn) (q)]	219	311	402
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	[(aa) (dd) (nn) (q)]	198	281	363
D6061	Abutment supported porcelain fused to metal crown (noble metal)	[(aa) (dd) (nn) (q)]	207	293	380
D6062	Abutment supported cast metal crown (high noble metal)	[(aa) (dd) (nn) (q)]	216	306	396
D6063	Abutment supported cast metal crown (predominantly base metall)	[(aa) (dd) (nn)]	189	267	346
D6064	Abutment supported cast metal crown (noble metal)	[(aa) (dd) (nn) (q)]	243	344	446
D6065	Implant supported porcelain/ceramic crown	[(aa) (dd) (nn) (q)]	234	332	429
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	[(aa) (dd) (nn) (q)]	234	332	429
D6067	Implant supported metal crown (titanium, titanium all, high noble metal)	[(aa) (dd) (nn) (q)]	233	330	427
D6068	Abutment supported retainer of porcelain/ceramic FPD	[(aa) (dd) (nn) (q)]	202	286	370
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	[(aa) (dd) (nn) (q)]	216	306	396
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominately base metal)	[(aa) (dd) (nn) (q)]	214	303	393
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	[(aa) (dd) (nn) (q)]	216	306	396
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	[(aa) (dd) (nn) (q)]	186	264	342
D6073	Abutment supported retainer for cast metal FPD (predominately base metal)	[(aa) (dd) (nn)]	198	281	363
D6074	Abutment supported retainer for cast metal FPD (noble metal)	[(aa) (dd) (nn) (q)]	202	286	370
D6075	Implant supported retainer for ceramic FPD	[(aa) (dd) (nn) (q)]	216	306	396

D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy or high noble metal)	[(aa) (dd) (nn) (q)]	225	319	413
D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy or high noble metal)	[(aa) (dd) (nn) (q)]	176	249	322
D6092	Recement of implant/abutment supported crown	[(d)]	16	23	30
D6093	Recement of implant/abutment supported fixed partial denture	[(d)]	23	32	41
D6210	Pontic - Cast High Noble Metal	[(aa) (dd) (q)]	158	223	289
D6211	Pontic - Cast Predominantly Base Metal	[(aa) (dd)]	146	207	267
D6212	Pontic - Cast Noble Metal	[(aa) (dd) (q)]	161	228	295
D6240	Pontic - Porcelain fused to High Noble Metal	[(aa) (dd) (q)]	163	232	300
D6241	Pontic - Porcelain fused to Predominantly Base Metal	[(aa) (dd) (q)]	146	207	268
D6242	Pontic - Porcelain fused to Noble Metal	[(aa) (dd) (q)]	156	222	287
D6245	Pontic - Porcelain/Ceramic	[(aa) (dd) (q)]	176	250	323
D6250	Pontic - Resin with High Noble Metal	[(aa) (dd) (q)]	162	230	297
D6251	Pontic - Resin with Predominantly Base Metal	[(aa) (dd) (q)]	144	204	264
D6252	Pontic - Resin with Noble Metal	[(aa) (dd) (q)]	153	217	281
D6545	Retainer - Cast Metal for Resin Fixed Prosthesis	[(aa) (dd) (q)]	72	102	132
D6548	Retainer - Porcelain/Ceramic (resin bonded fixed prosthesis)	[(aa) (dd) (q)]	86	121	157
D6600	Inlay – porcelain/ceramic, two surfaces	[(aa) (dd) (q)]	135	191	248
D6601	Inlay – Porcelain/ceramic, three or more surfaces	[(aa) (dd) (q)]	171	242	314
D6602	Inlay - cast high noble metal, two surfaces	[(aa) (dd) (q)]	126	179	231
D6603	Inlay - cast high noble metal, three or more surfaces	[(aa) (dd) (q)]	144	204	264
D6604	Inlay - cast predominantly base metal, two surfaces	[(aa) (dd)]	117	166	215
D6605	Inlay - cast predominantly base metal, three or more surfaces	[(aa) (dd)]	162	230	297
D6606	Inlay - cast noble metal, two surfaces	[(aa) (dd) (q)]	125	177	229
D6607	Inlay - cast noble metal, three or more surfaces	[(aa) (dd) (q)]	161	228	295
D6608	Onlay - porcelain/ceramic, two surfaces	[(aa) (dd) (q)]	161	229	296
D6609	Onlay - porcelain/ceramic, three or more surfaces	[(aa) (dd) (q)]	171	242	314
D6610	Onlay - cast high noble metal, two surfaces	[(aa) (dd) (q)]	144	204	264
D6611	Onlay - cast high noble metal, three or more surfaces	[(aa) (dd) (q)]	171	242	214
D6612	Onlay - cast predominantly base metal, two surfaces	[(aa) (dd)]	135	191	247
D6613	Onlay - cast predominantly base metal, three or more surfaces	[(aa) (dd)]	170	241	312
D6614	Onlay - cast noble metal, two surfaces	[(aa) (dd) (q)]	138	196	254
D6615	Onlay - cast noble metal, three or more surfaces	[(aa) (dd) (q)]	173	245	317
D6720	Crown - Resin with High Noble Metal	[(aa) (dd) (q)]	162	230	297
D6721	Crown - Resin with Predominantly Base Metal	[(aa) (dd)]	148	209	271
D6722	Crown - Resin with Noble Metal	[(aa) (dd) (q)]	149	212	274
D6740	Crown - Porcelain/Ceramic	[(aa) (dd) (q)]	178	252	326
D6750	Crown - Porcelain fused to High Noble Metal	[(aa) (dd) (q)]	166	235	304
D6751	Crown - Porcelain fused to Predominantly Base Metal	[(aa) (dd)]	149	210	272
D6752	Crown - Porcelain fused to Noble Metal	[(aa) (dd) (q)]	158	223	289
D6780	Crown - 3/4 Cast High Noble Metal	[(aa) (dd) (q)]	162	230	297
D6781	Crown - 3/4 Cast Predominately Based Metal	[(aa) (dd)]	153	217	281
D6782	Crown - 3/4 Cast Noble Metal	[(aa) (dd) (q)]	164	232	300
D6783	Crown - 3/4 Porcelain/Ceramic	[(aa) (dd) (q)]	180	255	330
D6790	Crown - Full Cast High Noble Metal	[(aa) (dd) (q)]	161	228	295
D6791	Crown - Full Cast Predominantly Base Metal	[(aa) (dd)]	149	210	272
D6792	Crown - Full Cast Noble Metal	[(aa) (dd) (q)]	162	230	297
D6930	Recement Fixed Partial Denture	[(d) (z)]	22	31	40
D6940	Stress breaker	[(aa) (dd)]	45	64	83
D6970	Post and core in addition to fixed partial denture retainer, indirectly fabricated	[(aa) (dd)]	57	81	105
D6972	Prefabricated post and core + retainer	[(aa) (dd)]	48	68	87
D6980	Fixed partial denture repair, by report	[(j) (z)]	36	51	66
D7111	Coronal remnants - deciduous tooth	[r]	34	48	63
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps	[r]	44	62	81

	removal)				
D7210	Surgical Removal of Erupted tooth requiring elevation of Mucoperiosteal Flap	[r]	41	57	74
D7220	Removal of Impacted tooth - Soft Tissue	[r]	49	70	90
D7230	Removal of Impacted tooth - Partially Bony	[r]	63	89	116
D7240	Removal of Impacted tooth - Completely Bony	[r]	72	102	132
D7241	Removal of Impacted tooth - Completely Bony, with unusual surgical complications	[r]	86	121	157
D7250	Surgical Removal of Residual tooth roots (cutting procedure)	[r]	45	63	82
D7260	Oroantral Fistula Closure	[r]	161	228	295
D7261	Primary closure of a sinus perforation	[r]	108	153	198
D7270	Tooth Reimplantation and/or stabilization of Accidentally Evulsed or Displaced	[(s)]	70	99	129
D7272	Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization	[r]	99	140	182
D7280	Surgical access of an unerupted tooth	[r]	81	115	149
D7281	Surgical Exposure of Impacted or Unerupted tooth to Aid Eruption	[(s)]	81	115	149
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	[r]	41	57	74
D7285	Biopsy of Oral Tissue - Hard (bone, tooth)	[(ee)]	79	112	145
D7286	Biopsy of Oral Tissue - Soft (all others)	[(ee)]	54	77	100
D7287	Cytology sample collection		23	32	41
D7310	Alveoloplasty in conjunction with Extractions - per quadrant	[(bb)]	39	55	71
D7320	Alveoloplasty not in conjunction with Extractions - per quadrant	[(bb)]	54	77	100
D7340	Vestibuloplasty - Ridge Extension (secondary Epithelialization)	[(s)]	153	217	281
D7410	Radical Excision - Lesion Diameter up to 1.25 Cm	[(ee)]	68	96	124
D7411	Excision of benigh lesion greater than 1.25 cm	[(ee)]	108	153	198
D7412	Excision of benign lesion, complicated	[(ee)]	171	242	314
D7413	Excision of malignant lesion up to 1.25 cm	[(ee)]	94	133	172
D7414	Excision of malignant lesion greater that 1.25 cm	[(ee)]	163	231	299
D7440	Excision of Malignant Tumor-Lesion Diameter up to 1.25 Cm	[(ee)]	179	254	328
D7441	Excision of Malignant Tumor - Lesion Diameter greater than 1.25 Cm	[(ee)]	180	255	330
D7450	Removal of Odontogenic Cyst or Tumor - Lesion Diameter up to 1.25 Cm	[(ee)]	81	115	149
D7451	Removal of Odontogenic Cyst or Tumor - Lesion Diameter greater than 1.25 Cm	[(ee)]	135	191	248
D7460	Removal of Nonodontogenic Cyst or Tumor - Lesion Diameter up to 1.25 Cm	[(ee)]	80	113	146
D7461	Removal of Nonodontogenic Cyst or Tumor - Lesion Diameter greater than 1.25 Cm	[(ee)]	119	169	218
D7465	Destruction of lesion(s) by physical or chemical method, by report		45	64	83
D7471	Removal of Exostosis - per site (up to maximum of 3 sites)	[(s)]	90	128	165
D7472	Removal of torus palatinus (up to 1 site)	[(s)]	117	165	214
D7473	Removal of torus mandibularis (up to 2 sites)	[(s)]	100	142	183
D7485	Surgical reduction of osseous tuberosity	[(s)]	82	117	151
D7510	Incision and Drainage of Abscess - Intraoral Soft Tissue		33	47	61
D7520	Incision and Drainage of Abscess - Extraoral Soft Tissue	[(x)]	113	159	206
D7530	Removal of Foreign Body, Skin, or Subcutaneous Alveolar Tissue	[s)]	45	64	83
D7540	Removal of reaction-producing foreign bodies – musculoskeletal system	[(s)]	68	96	124
D7550	Partial Ostectomy/Sequestrectomy	[s)]	48	68	87
D7560	Maxillary Sinusotomy	[(s)]	216	306	396
D7910	Suture of Recent Small Wounds to 5 Cm (not associated with periodontal or oral surgery procedure)		27	38	50
D7960	Frenulectomy (Frenectomy or Frenotomy) - separate procedure	[(bb)]	65	92	119
D7970	Excision of Hyperplastic Tissue - per arch		59	83	107
D7972	Surgical reduction of fibrous	[(s)]	54	77	99
D7980	Sialolithotomy		86	122	158

D7983	Closure of salivary fistula		217	308	399
D8210	Removable appliance therapy (for harmful habit control only)	[(s)]	84	119	154
D8220	Fixed appliance therapy (for harmful habit control only)	[(s)]	84	119	154
D9110	Palliative (emergency) treatment of dental pain - minor procedure	[(d)]	16	23	29
D9120	Fixed partial denture sectioning	[(s)]	18	26	33
D9220	General Anesthesia - first 30 minutes	[(t) (ll)]	61	86	111
D9221	General Anesthesia - each additional 15 minutes	[(t) (ll)]	23	33	42
D9241	IV Sedation/Analgesia - first 30 mins	[(t) (ll)]	57	80	104
D9242	IV Sedation/Analgesia - each additional 15 minutes	[(t) (ll)]	19	27	35
D9440	Office Visit - after regularly scheduled hours	[(d) (x)]	21	30	39
D9911	–Application of desensitizing resin for cervical and/or root surface, per tooth	[(y) (d)]	8	11	15
D9930	Treatment of complications (post-surgical) – unusual circumstances, by report	[(x) (d) (p)]	13	18	23

Policy Schedule

Named Insured:	[*John Doe*]	Policy Number:	[*XXXXXXXX*]
Address:	[*123 Any Street*]	Coverage:	[*Value Plan, Standard Plan, Preferred Plan, Waiting Period [0,12], Vision Rider, TMJ Rider*]
	[*Anyville, State 12345*]	Policy Effective Date:	[*XX/XX/20XX*]
Type Of Coverage:	[*Individual*]	Covered Dependents:	[*Mary Doe, Spouse*]
Policy Premiums:	[$*XX.XX*]	Mode Of Payment:	[*Annual, Semi-Annual, Quarterly, Monthly*]

Benefits

Dental Benefits

Policy Year Benefit Maximum:
Benefit Maximum Amount: [*$1000*]

Policy Year Deductible:
Deductible Limit: 3 per family
Deductible Waived for Type 1 Services: [*Yes*]
Deductible Amount: [*$50*]

Type 1 - Preventive Services:
Waiting Periods: *0* months
Covered Dental Expenses: [Lesser of the actual charge and Schedule Amount]
Note: Refer to the Schedule of Covered Procedures for a full explanation of Type 1 – Preventive Services.

Type 2 - Basic Services:
Waiting Periods: *0* months
Covered Dental Expenses: [*Lesser of the actual charge and Schedule Amount*]
Note:Refer to the Schedule of Covered Procedures for a full explanation of Type 2 – Basic Services.

[Type 3 – Major Services:
Waiting Periods: [*0 or 12*] months
Covered Dental Expenses: [*Lesser of the actual charge and Schedule Amount*]
Note:Refer to the Schedule of Covered Procedures for a full explanation of Type 3 – Major Services.]

Type of Coverage

[Temporomandibular Joint Treatment Expense Rider:
Waiting Periods: 12 months
Lifetime Maximum: [$0 or $500]
Covered Dental Expenses: [*Lesser of the actual charge and Schedule Amount*]
Note:Refer to the Rider for a full explanation of Temporomandibular Joint Treatment Services.]

[Vision Rider Benefits

Schedule of Benefits

FREQUENCY OF SERVICES Your Policy is on a Rolling Benefit Plan Basis	
Vision Exam:	Once every 12 Months
Eyeglass Lenses:	Once every 12 Months
Frames:	Once every 12 Months
Contact Lenses:	Once every 12 Months

CO-PAY (PER COVERED PERSON)		
	Participating Providers:	Non-Participating Provider:
Vision Exam:	$15.00	See Below
Eyeglass Lenses:	$20.00	See Below
Frames:	$20.00	See Below
Contact Lenses:	$20.00	See Below

BENEFITS AND ALLOWANCES [1]

	Participating Providers:	Non-Participating Provider:
Vision Exam:		
By Ophthalmologist	Covered in Full (Subject to Co-Pay)	$35 Allowance
By Optometrist	Covered in Full (Subject to Co-Pay)	$35 Allowance
Materials- Eyeglass Lenses [3:]		
Single Vision	Covered in Full (Subject to Co-Pay)	Up to $25
Bifocals	Covered in Full (Subject to Co-Pay)	Up to $40
Progressives	up to $70.00 Allowance	Up to $40
Trifocals	Covered in Full (Subject to Co-Pay)	Up to $50
Lenticular	up to $80.00 Allowance	Up to $50
Materials – Frames[3:]:	$100 Allowance	Up to $50
Materials – Contact Lenses[2]:		
Non-Elective	$210 Allowance	$210
Elective	$120 Allowance	$100

[1] Where an "Allowance" is shown, You are responsible for paying any charges in excess of the Allowance.

[2] The Contact Lenses benefit is paid in lieu of Eyeglass Lenses and Frames. Contact Lenses consist of (3) components: materials, exams and fittings. Coverage is for materials and the exam, up to the Contact Lenses allowance. Fittings may be covered but only up to the amount of any unused Contact Lenses allowance – after Materials.

[3] Eyeglass Lenses and Frames are paid in lieu of the Contact Lenses benefit.]

4-Tier:
Individual - coverage for only You, the covered person listed in the Policy Schedule of Benefits.
Individual and Spouse - coverage for You, the covered person, and Your spouse.
Individual and Children - coverage for You, the covered person, and all Your dependent children.
Individual and Family - coverage for You, the covered person, Your spouse and all Your dependent children.]

SERFF Tracking Number:	*STAR-126385934*	*State:*	*Arkansas*
Filing Company:	*Starmount Life Insurance Company*	*State Tracking Number:*	*44096*
Company Tracking Number:			
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*Individual Dental Policy*		
Project Name/Number:	*/IDN-2009*		

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	11/19/2009

Comments:

Attachment:

Flesch Readability.pdf

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved-Closed	11/19/2009

Comments:

Application attached under FORMS

		Item Status:	Status Date:
Satisfied - Item:	Outline of Coverage	Approved-Closed	11/19/2009

Comments:

Attachment:

IDN2009 Outline of Coverage-10-09.pdf

STARMOUNT LIFE INSURANCE COMPANY

FLESCH READABILITY ANALYSIS

FORM	WORDS	PARAGRAPHS	SENTENCES	SCORE
IDN-2009-IN	884	49	50	50.6
IDN-2009 Application	339	68	12	50.4
IDN2009-SCP	143	4	9	50.2
IDN2009-SOB	512	96	34	52.2
IDNTMJ-2009	403	24	16	51.5
IDNVR-2009	1540	79	79	50.3

This is to certify that this form meets the minimum score on the Flesch reading ease test in the NAIC Life and Health Insurance Policy Language Simplification Model Act. The Flesch score has been measured by the method described in the act and reflects all text excluding only language or terminology in the following categories entitled to be excepted under the act: the name and address of the insurer; the name, number or title of the policy; the table of contents or index; captions and subcaptions; specifications pages, schedules or table; language required by law or regulation; medical terminology; and words which are defined in the policy.

Jeffrey G. Wild

Digitally signed by Jeffrey G. Wild
DN: cn=Jeffrey G. Wild, c=US, o=Starmount Life, ou=Financial, email=JeffW@Starmountlife.com
Date: 2009.11.16 14:35:09 -06'00'

Jeffrey G. Wild
Chief Financial Officer
Starmount Life Insurance Company

DATE: 11/16/2009

Starmount Life Insurance Company

[Home Office: 7800 Office Park Blvd, PO Box 98100
Baton Rouge, LA 70898-9100]
Toll Free Telephone No: 1-888-729-5433

DENTAL INSURANCE POLICY

Outline of Coverage for Policy Form Series IDN-2009

THIS IS NOT MEDICARE SUPPLEMENT COVERAGE

(1) Read Your Policy Carefully: This Outline of Coverage provides a very brief description of some of the important features of Your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth, in detail, the rights and obligations of both You and Us. It is therefore, important that You READ YOUR POLICY CAREFULLY.

(2) Type 1 Preventive Services:

We will pay the following benefits when a charge is incurred for a Covered Dental Procedure that occurs while coverage is in force. Benefits will be paid only for the specific procedure codes listed in the policy.

Type 1 Preventive Services are paid at 100% of the amount listed in the Schedule of Covered Procedures, as shown in the Policy Schedule of Benefits. Payments are subject to the Policy Year Deductible and Plan Maximum. A Dentist or Dental Hygienist must perform these treatments.

We will pay the lesser of the actual charge and the Schedule Amount.

TYPE 1 – PREVENTIVE – ORAL EVALUATIONS
TYPE 1 – PREVENTIVE - RADIOGRAPHS
TYPE 1 – PREVENTIVE - FLUORIDE
TYPE 1 – PREVENTIVE – ORTHODONTICS
TYPE 1 – BASIC – SEALANTS
TYPE 1 – PREVENTIVE – SPACE MAINTAINCE

(3) Type 2 Basic Services:

We will pay the following benefits when a charge is incurred for a Covered Dental Procedure that occurs while coverage is in force. Benefits will be paid only for the specific procedure codes listed in the policy.

Type 2 Basic Services are paid at 100% of the amount listed in the Schedule of Covered Procedures, as shown in the Policy Schedule of Benefits. Payments are subject to the Policy Year Deductible and Plan Maximum. A Dentist must perform these treatments.

We will pay the lesser of the actual charge and the Schedule Amount.

TYPE 2 – BASIC – AMALGAM RESTORATION
TYPE 2 – BASIC – RESIN BASED COMPOSITE RESTORATIONS
TYPE 2 – BASIC – SIMPLE EXTRACTIONS

(4) Type 3 Major Services:

We will pay the following benefits when a charge is incurred for a Covered Dental Procedure that occurs while coverage is in force. Benefits will be paid only for the specific procedure codes listed in the policy.

After any applicable waiting periods stated in Your policy, Type 3 Major services are paid at 100% of the amount listed in the Schedule of Covered Dental Procedures, as shown in the Policy Schedule of Benefits. Payments are subject to the Policy Year Deductible and Plan Maximum. A Dentist must perform these treatments.

We will pay the lesser of the actual charge and the Schedule Amount.

TYPE 3 – MAJOR – SINGLE TOOTH RESTORATIONS (INLAYS, ONLAYS & CROWNS)
TYPE 3 – MAJOR – ENDODONTICS
TYPE 3 – MAJOR – PERIODONTICS
TYPE 3 – MAJOR – ORAL SURGERY
TYPE 3 – MAJOR – IMPLANT SERVICES
TYPE 3 – MAJOR – ADJUNCTIVE SERVICES
TYPE 3 – MAJOR – DENTURES
TYPE 3 – MAJOR – PONTICS

(TEMPOROMANDIBULAR) JOINT TREATMENT EXPENSE RIDER)

After Your policy has been in force for 12 months, We will pay 100% of the amount listed in the rider for each procedure listed in Your rider for treatment involving any of the listed temporomandibular joint procedures. There is a lifetime maximum of **$500** per covered person. See Your rider schedule for the specific procedures covered under this rider.

(**VISION BENEFITS RIDER)**

A Covered Person may choose to receive vision care services from either a Participating Provider or a Non-Participating Provider.

Schedule of Benefits

FREQUENCY OF SERVICES Your Policy is on a Rolling Benefit Plan Basis	
Vision Exam:	**Once every 12 Months**
Eyeglass Lenses:	**Once every 12 Months**
Frames:	**Once every 12 Months**
Contact Lenses:	**Once every 12 Months**

CO-PAY (PER COVERED PERSON)		
	Participating Providers:	**Non-Participating Provider:**
Vision Exam:	**$15.00**	**See Below**
Eyeglass Lenses:	**$20.00**	**See Below**
Frames:	**$20.00**	**See Below**
Contact Lenses:	**$20.00**	**See Below**

BENEFITS AND ALLOWANCES [1]

	Participating Providers:	**Non-Participating Provider:**
Vision Exam:		
By Ophthalmologist	**Covered in Full (Subject to Co-Pay)**	**$35 Allowance**
By Optometrist	**Covered in Full (Subject to Co-Pay)**	**$35 Allowance**
Materials- Eyeglass Lenses [3]:		
Single Vision	**Covered in Full (Subject to Co-Pay)**	**Up to $25**
Bifocals	**Covered in Full (Subject to Co-Pay)**	Up to $40
Progressives	**up to $70.00 Allowance**	Up to $40
Trifocals	**Covered in Full (Subject to Co-Pay)**	Up to $50
Lenticular	**up to $80.00 Allowance**	Up to $50

Materials – Frames[3]:	**$100 Allowance**	Up to $50
Materials – Contact Lenses[2]:		
Non-Elective	**$210 Allowance**	**$210**
Elective	**$120 Allowance**	**$100**

[1] **Where an "Allowance" is shown, You are responsible for paying any charges in excess of the Allowance.**

(7) Limitations and Exclusions of This Policy:

A. This policy does not cover losses caused by or resulting from any of the following. In addition, the procedures listed below will not be recognized toward satisfaction of any Policy Year Deductible.

1. Any procedure or service not shown on the Schedule of Covered Procedures or the Policy Schedule.
2. Amounts in excess of the Policy Year Benefit Maximum.
3. Services or supplies We consider being experimental or investigative.
4. Any injury or illness when covered under Worker's Compensation or similar law, or which is work related.
5. Services received before a Covered Person's effective date, including started but not completed services.
6. Services received after, or started but not completed within 30 days of a Covered Person's coverage ending.
7. Charges for dental services performed by other than a licensed dentist or dental hygienist.
8. Services that are not recommended by a dentist or that are not required for the preservation or restoration of oral health.
9. Repairs or adjustments to dental work within six months of the initial work.
10. Replacement prosthetics within seven years of last placement.
11. Treatment involving crowns for a given tooth within seven years of last placement, regardless of the type of crown.
12. Replacement for inlays or onlays for a given tooth within seven years of last placement.
13. Any services performed for convenience or cosmetic purposes.
14. Any charge for a service required as a result of disease or injury that is due to war or an act of war (whether declared or undeclared); taking part in an insurrection or riot; the commission or attempted commission of a crime; an intentionally self-inflicted injury or attempted suicide while sane or insane.
15. Services performed by a Dentist who is a member of the covered person's Immediate Family.
16. [Except as provided under the TMJ Expense Rider.]

A. No benefits will be paid for replacement of teeth missing prior to the effective date of coverage.
B. No benefits will be paid for the initial placement of removable full or partial dentures, unless it includes the replacement of a Functioning Natural Tooth extracted while the covered person is insured under this policy.
C. No benefits will be paid for the initial placement of a fixed partial denture including a Maryland Bridge, unless it includes the replacement of a Functioning Natural Tooth extracted while the covered person is insured under this policy.
D. Regardless of optical necessity, the Vision Benefits are not available more frequently than specified in the Policy Schedule of Benefits.
E. Federal, state or local taxes are not included as part of a Covered Dental Expense.
F. See the Schedule of Covered Dental Procedures for all specific procedure limitations.

(8) Renewability: You can keep Your policy in force as long as You pay Your premium on time. It must be paid by the due date or during the 31 day Grace Period. We may change the premium rates effective at renewal dates for Each Subsequent Policy Year. We will not change Your premium unless the same change is made on all policies of this form in the state where you live. We will notify You in writing at Your last known address at least 30 days before the change becomes effective.

RETAIN FOR YOUR RECORDS.
THIS OUTLINE OF COVERAGE IS ONLY A BRIEF SUMMARY OF THE COVERAGE PROVIDED.
THE POLICY ITSELF SHOULD BE CONSULTED TO DETERMINE
GOVERNING CONTRACTUAL PROVISIONS.

SERFF Tracking Number:	*STAR-126385934*	*State:*	*Arkansas*
Filing Company:	*Starmount Life Insurance Company*	*State Tracking Number:*	*44096*
Company Tracking Number:			
TOI:	*H10I Individual Health - Dental*	*Sub-TOI:*	*H10I.000 Health - Dental*
Product Name:	*Individual Dental Policy*		
Project Name/Number:	*/IDN-2009*		

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
11/16/2009	Form	Individual Dental Policy	11/18/2009	IDN-2009-AR POLICY.pdf (Superceded)
11/16/2009	Form	Individual Dental Policy	11/16/2009	IDN-2009-AR POLICY.pdf (Superceded)

Starmount Life Insurance Company

[Home Office: 7800 Office Park Blvd., P.O. Box 98100, Baton Rouge, LA 70898-9100
Administrative Office: AlwaysCare Benefits, Inc., 7800 Office Park Blvd, PO Drawer 14389
Baton Rouge, LA 70898-4389]
Toll Free Telephone No: 1-888-729-5433

LIMITED BENEFITS HEALTH INSURANCE
DENTAL INSURANCE POLICY
[with Vision and TMJ Benefits Rider]

The Named Insured as shown in the Policy Schedule will be referred to as "You", "Your" or "Yours". Starmount Life Insurance Company will be referred to as "We", "Our" or "Us".

IMPORTANT
This is a dental policy [with [Vision] and [TMJ Benefits Rider]]. Read it carefully with the Outline of Coverage, if applicable.

CONSIDERATION
This policy is issued in consideration of the statements made in Your application and the payment of the premium shown in the Policy Schedule. A copy of Your application is attached and is part of this policy. The following paragraphs set forth the insurance benefits, limitations and exclusions, definitions of terms, and other provisions.

TERM
The term of this policy begins at noon, standard time, at the place where You reside on the effective date shown in the Policy Schedule. It ends at noon, the same standard time, on the first renewal date. Each renewal term ends at noon, the same standard time, on the next following renewal date. Renewal dates are determined by the mode of payment. The mode of payment for the original term of the policy is shown in the Policy Schedule. An annual premium will maintain the policy in force for 12 months, semiannual for six months, quarterly for three months.

30-DAY RIGHT TO EXAMINE THIS POLICY
It is important to Us that You are satisfied with this policy and that it meets Your insurance goals. If You are not satisfied, You may return it within 30 days after You receive it. You will receive a full refund of all premiums paid, and Your policy will be void from its effective date. If You return the policy, please note in writing: "This policy is returned for cancellation and refund of premium."

IMPORTANT NOTICE
Please read Your application attached to this policy. This policy is issued on the basis that the information shown on the application is correct and complete to the best of Your knowledge and belief. Carefully check the application. Write to Us within 30 days of the date You receive this policy if any information shown on it is not correct or complete. Incorrect information can result in the denial of a claim or termination of the policy. No duly licensed agent may change this policy or waive any of its provisions.

GUARANTEED RENEWABLE. WE HAVE THE RIGHT TO CHANGE PREMIUM RATES.
You can keep Your policy in force as long as You pay Your premium on time. It must be paid by the due date or during the 31 day Grace Period. We may change the premium rates effective at renewal dates for Each Subsequent Policy Year. We will not change Your premium unless the same change is made on all policies of this form in the state where you live. We will notify You in writing at Your last known address at least 30 days before the change becomes effective.

THIS IS A NON-PARTICIPATING POLICY

INDEX

POLICY SCHEDULE

Insert Policy Schedule here.

Part 1
DEFINITIONS

A. CLAIM: a request for payment of benefits under this policy.

B. COVERED DENTAL EXPENSE: is the lesser of the actual charge or the Schedule Amount.

C. COVERED DENTAL PROCEDURE: any procedure listed in the Schedule of Covered Procedures.

D. COVERED PERSONS: are any persons listed in the Policy Schedule.

Newborn children are automatically covered under the terms of the policy from the moment of birth, and adopted children are covered from the date of petition. Coverage for newborn or adopted children will be in effect until the 31st day following the date of such event. If You desire uninterrupted coverage for a newborn or an adopted child, You must notify Us within 31 days of the child's birth or the date of petition for adoption.

Upon notification, We will convert this policy to the Type of Coverage You requested and advise You of the additional premium due, if any. If You wish any other person to be covered after the effective date of the policy, You must apply for such coverage, and that person must be added by endorsement. Insurance for persons added by endorsement becomes effective on the date specified on the endorsement.

The insurance of any Dependent Child will terminate on the policy anniversary date following the end of the month of the child's 26th birthday, the child's marriage, or at the time the child no longer qualifies as a legal dependent for tax exemption purposes under the Unites States Revenue Service Tax Code, whichever occurs first. Termination will be without prejudice to any claim originating prior hereto. Our acceptance of premium after such date will be considered as premium for only the remaining persons who qualify as covered persons under the policy. Coverage provided under a Type of Coverage listed in the Policy Schedule, which includes Dependents, will include any other unmarried dependent child, regardless of age, who is incapable of self-sustaining employment by reason of mental retardation or physical handicap and who became so incapacitated before age 26. You must furnish proof of such incapacity and dependency to Us within 31 days of the dependent child's 26th birthday. At Our request You must furnish proof of loss of continued incapacity and dependency, but not more often than annually after the two-year period following the end of the month of the child's 26th birthday.

In the event of Your death, Your spouse, if covered by this policy, will become the Named Insured.

E. DENTAL HYGIENIST: a legally qualified person, other than a member of Your Immediate Family, who is licensed by the state to treat the type of condition for which a claim is made.

F. DENTIST: a legally qualified person, other than a member of Your Immediate Family, who is licensed by the state to treat the type of condition for which a claim is made.

G. DEPENDENT CHILDREN: are Your natural children, stepchildren or legally adopted children who are unmarried, who are under 19 years of age and who qualify as legal dependents for tax exemption purposes under the United States Internal Revenue Service Tax Code. Coverage of a dependent child will be extended through age 24 if he/she is enrolled as a full-time student in an accredited post-secondary institution of higher learning for five calendar months in that calendar year or, if not enrolled, would have been eligible to enroll and was prevented from enrolling due to sickness or injury. Children born to dependent children of You or Your spouse are not covered under this policy.

H. FUNCTIONING NATURAL TOOTH: means a tooth which is performing its normal role in the mastication (chewing) process in the covered person's upper or lower arch and which is opposed in the person's other arch by another tooth or prosthetic (i.e. artificial) replacement. Third molars are not considered Functioning Natural Teeth for purposes of this policy.

I. IMMEDIATE FAMILY: anyone related to You in the following manner: spouse; brother or sister (includes stepbrother and stepsister); children (includes stepchildren); parents(s) (includes stepparents); grandchildren; father- or mother-in-law;) and spouses as applicable, of any of these.

J. IN-NETWORK BENEFITS: The dental benefits provided under this Certificate for Covered Procedures that are provided by a Participating Provider.

K. NON-PARTICIPATING PROVIDER: A dentist or dental hygienist who is not a Participating Provider. These Non-Participating Providers have not entered into an agreement with us to limit their charges.

L. OUT-OF-NETWORK BENEFITS: The dental benefits provided under this Certificate for Covered Procedures that are not provided by a Participating Provider.

M. PARTICIPATING PROVIDER: A dentist or dental hygienist who has been selected by Us for inclusion in the Participating Provider Program. These Participating Providers agree to accept Our Participating Provider Maximum Allowed Charges as payment in full for services rendered. When dental care is given by Participating Providers, the Insured will generally incur less out-of-pocket cost for services rendered.

N. PARTICIPATING PROVIDER PROGRAM: Our program to offer an Insured the opportunity to receive dental care from dentists who are designated by Us as Participating Providers.

O. PATRICIPATING PROVIDER PROGRAM DIRECTORY: The list which consists of selected Participating Providers who:

1. are located in Your area; and
2. have been selected by Us to be Participating Providers and part of the Participating Provider Program.

The list will be periodically updated.

P. POLICY YEAR: Policy Year includes the First Policy Year and each subsequent Policy Year.

1. **First Policy Year:** the period of time that begins on the effective date of coverage as shown in the Policy Schedule and ends 365 days from the effective date.

2. **Each Subsequent Policy Year:** every 12-month period thereafter.

Q. POLICY YEAR DEDUCTIBLE: the amount shown in the Policy Schedule. This amount applies to each Covered Person and must be satisfied once each Policy Year before benefits are payable for Covered Dental Expenses.

R. POLICY YEAR BENEFIT MAXIMUM: the amount shown in the Policy Schedule. This amount applies to each Covered Person and is the maximum amount paid for Covered Dental Expenses per Policy Year.

S. RENEWAL DATE: is the yearly anniversary date of the policy. The first Renewal Date is 365 days from the effective date of coverage. Each subsequent Renewal Date is 365 days from the prior Renewal Date.

T. SCHEDULE AMOUNT: the amount shown in the Schedule of Covered Procedures.

U. SCHEDULE OF COVERED PROCEDURES: a listing of all Covered Dental Procedures and the corresponding Schedule Amounts.

V. TREATMENT PLAN: is the Dentist's report of recommended treatment on a form satisfactory to Us which:

a. itemizes the dental Services with ADA codes, dates of service(s) and charges required for the Necessary care of the mouth;

b. lists the charges for each Service; and

c. is accompanied by supporting pre-operative X-rays and any other appropriate diagnostic materials required by Us.

W. TYPE OF COVERAGE: (see Your Policy Schedule to determine the type of coverage in force)

X. WAITING PERIOD: the period after the effective date of coverage for which benefits are not payable. In the event of a reinstatement, all covered persons will be subject to new Waiting Periods beginning with the effective date of reinstatement. If a dependent is added by endorsement, the Waiting Period will begin from the effective date of the addition. The Waiting Period will vary based on type of service (see the Policy Schedule).

DESCRIPTION OF BENEFITS

DENTAL BENEFITS: Subject to the Waiting Period, Policy Year Deductible, Policy Year Benefit Maximum, listed in the Policy Schedule, and Limitations and Exclusions, we will pay for services listed in the Schedule of Covered Procedures up to Covered Dental Expense amount when a charge is incurred for a Covered Dental Procedure that occurs while coverage is in force.

CHOICE OF PROVIDERS: An Covered Person may choose the services of a Participating Provider who is either a Participating Provider or a Non-Participating Provider. Benefits under this Policy are determined and payable in either case. If a Participating Provider is chosen, the Covered Person will generally incur less out-of-pocket cost.

Part 3
LIMITATIONS AND EXCLUSIONS

A. This policy does not cover losses caused by or resulting from any of the following. In addition, the procedures listed below will not be recognized toward satisfaction of any Policy Year Deductible.

1. Any procedure or service not shown on the Schedule of Covered Procedures or the Policy Schedule.
2. Amounts in excess of the Policy Year Benefit Maximum.
3. Services or supplies We consider being experimental or investigative.
4. Any injury or illness when covered under Worker's Compensation or similar law, or which is work related.
5. Services received before a Covered Person's effective date, including started but not completed services.
6. Services received after, or started but not completed within 30 days of a Covered Person's coverage ending.
7. Charges for dental services performed by other than a licensed dentist or dental hygienist.
8. Services that are not recommended by a dentist or that are not required for the preservation or restoration of oral health.
9. Repairs or adjustments to dental work within six months of the initial work.
10. Replacement prosthetics within seven years of last placement.
11. Treatment involving crowns for a given tooth within seven years of last placement, regardless of the type of crown.
12. Replacement for inlays or onlays for a given tooth within seven years of last placement.
13. Any services performed for convenience or cosmetic purposes.
14. Any charge for a service required as a result of disease or injury that is due to war or an act of war (whether declared or undeclared); taking part in an insurrection or riot; the commission or attempted commission of a crime; an intentionally self-inflicted injury or attempted suicide while sane or insane.
15. Services performed by a Dentist who is a member of the covered person's Immediate Family.
16. [Except as provided under the TMJ Expense Rider.]

B. No benefits will be paid for replacement of teeth missing prior to the effective date of coverage.
C. No benefits will be paid for the initial placement of removable full or partial dentures, unless it includes the replacement of a Functioning Natural Tooth extracted while the covered person is insured under this policy.
D. No benefits will be paid for the initial placement of a fixed partial denture including a Maryland Bridge, unless it includes the replacement of a Functioning Natural Tooth extracted while the covered person is insured under this policy.
E. Federal, State or local taxes are not included as part of a Covered Dental Expense.
F. See the Schedule of Covered Dental Procedures for all specific procedure limitations.

Part 4
INSURANCE WITH OTHER INSURERS

If there is other valid coverage, not with Us, providing benefits for the same loss on a provision of service basis or on an expense incurred basis and of which We have not been given written notice prior to the occurrence or commencement of loss, the only liability under any expense incurred coverage of this Policy will be for the proportion of the loss as the amount which would otherwise have been payable under this policy plus the total of the like amounts under all the other valid coverages for the same loss of which We had notice bears to the total like amounts under all valid coverages for the loss, and for the return of the portion of the premiums paid as shall exceed the pro-rata portion for the amount so determined. For the purpose of applying this provision when other coverage is on a provision of service basis, the "like amount" of the other coverage shall be taken as the amount that the services rendered would have cost in the absence of the coverage.

Part 5
RIGHT OF CONVERSION

If You or Your spouse dissolve Your marriage by a valid decree of dissolution of marriage and Your spouse was a Covered Person, then Your ex-spouse can apply for and receive, without evidence of insurability, a policy providing coverage not greater than the terminated coverage. To obtain the policy, Your ex-spouse must make application to Us within 60 days following the entry of the decree of dissolution of marriage. If such dissolution of marriage occurs, the Named Insured under this policy at the time of dissolution will retain that status. Any covered dependent may be covered under either policy, but not both.

Part 6
GENERAL POLICY PROVISIONS

A. ENTIRE CONTRACT; CHANGES: This policy, together with the application, endorsements, benefit agreements, riders and attached papers, if any, is the entire contract of insurance. No change in the policy is valid until approved in writing by Our president and secretary. This approval must be noted on or attached hereto. No duly licensed agent may change this policy or waive any of its provisions.

B. TIME LIMIT ON CERTAIN DEFENSES: (a) After two years from the effective date of coverage, no misstatements, except fraudulent misstatements, made by the applicant in the application will be used to void the coverage or to deny a claim for a loss incurred after the expiration of such two-year period. (b) No claim for loss incurred or disability (as defined in the Policy) commencing after two years from the date of issue of this policy will be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this Policy.

C. GRACE PERIOD: A grace period of 31 days will be granted for the payment of each premium falling after the first premium. During the grace period, this policy shall continue in force.

D. REINSTATEMENT: You may request reinstatement of Your policy directly from Us. If Your policy has lapsed for nonpayment of premium and We accept a later payment without requiring an application, Your policy will be reinstated. If We require a written application and provide You with a conditional receipt, Your policy will be reinstated upon approval of the applications from Us. If We do not notify You of Your disapproval in writing within 45 days of the date of Your application, Your policy shall be deemed reinstated. The reinstated policy shall cover loss resulting only from Covered Dental Procedures that occur after the date of reinstatement. In all other respects, You and Us shall have the same rights as provided under the policy immediately before the due date of the defaulted premium, subject to new Waiting Periods beginning with the effective date of reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period prior to the date of reinstatement.

E. NOTICE OF CLAIM: Written notice of claim must be given within 60 days after a Covered Dental Procedure starts or as soon as reasonably possible. Notice given by You or on Your behalf or on behalf of Your beneficiary to Us at [7800 Office Park Blvd, PO Drawer 14389, Baton Rouge, LA 70898-4389], or to any of Our authorized agents, with information sufficient to identify You, will be deemed notice to Us.

F. CLAIM FORMS: When We receive a notice of claim, We will send the claimant forms for filing proof of loss. If the forms are not given to You within 10 working days after the giving of such notice, You will meet the proof of loss requirements by submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

G. PROOF OF LOSS: Written proof of loss must be given to Us in case of claim for loss for which this Policy provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which We are liable, and in case of claim for any other loss within 90 days after the date of such loss. Failure to furnish such proof within the time required will not invalidate or reduce any claim if it was not reasonably possible to give proof within such time. However, such proof must be furnished as soon as reasonably possible and in no event (except in the absence of legal capacity) later than 12 months from the time of proof is otherwise required.

H. TIME OF PAYMENT OF CLAIMS: benefits payable under this policy will be paid immediately upon Our receipt of written proof of loss.

I. PAYMENT OF CLAIMS: All benefits will be payable to You unless assigned by You or by operation of law. Any accrued benefits unpaid at Your death will be paid to Your estate.

J. CLAIMS REVIEW PROCEDURE: If a claim is denied in whole or in part, You may request a review of the claim. The request must be in writing and must be made within 6 months after the claim was denied. Send the request to Us at P.O. Box 98100, Baton Rouge, LA 70898-9100. The request should contain any facts that the Insured considers important to the review. We will review the claims decision and send a response in writing within thirty (30) days. If the denial of benefits is confirmed, You will be told the reasons for the decision.

K. LEGAL ACTIONS: No legal action may be brought to recover on this policy within 60 days after written proof of loss has been given as required. No such action may be brought after six years from the time written proof of loss is required to be given.

L. CONFORMITY WITH STATE AND FEDERAL STATUTES: Any provisions of this policy that on its effective date is in conflict with the statutes of the state in which it was issue or with any federal statutes is hereby amended to conform to the minimum requirements of such statutes.

M. OTHER INSURANCE WITH THIS INSURER: If any person is covered under more than one policy or rider from Us, only the one chosen by You, Your beneficiary or Your estate, as the case may be, will be effective. We will return all premiums paid for that person for all other dental coverage from the date of duplication.

N. PRE-ESTIMATION OF BENEFITS: Whenever the estimated cost of a recommended dental Treatment Plan exceeds $300, the Treatment Plan may be submitted to Us for review before treatment begins. The Treatment Plan should be accompanied by supporting pre-operative X-rays and any other appropriate diagnostic materials that We or Our dental consultants request. We will notify the covered person and the attending Dentist of the estimated benefits payable based upon the Treatment Plan. In determining the amount of benefits payable, consideration will be given to alternate procedures that may accomplish a professionally satisfactory result. If the covered person and His Dentist decide on a more expensive method of treatment than that pre-estimated by Us, benefits will be paid for the more costly treatment, but only up to the Policy liability for the less expensive alternate Service. We will not pay the excess amount. Since this may result in significant out-of-pocket expense, We strongly encourage You to follow the pre-estimation procedure for any Treatment Plan which will exceed $300 in cost. Pre-Estimation of Benefits is not a promise of payment.

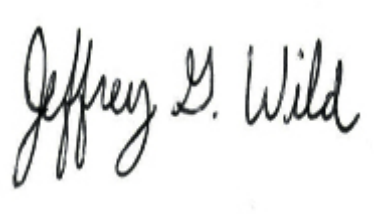
O. SERVICES PERFORMED OUTSIDE THE U.S.A.: Any Claim submitted for procedures outside the U.S.A. must: (1) be for a Covered Procedure, as defined; (2) be supplied in English; (3) use American Dental Association (ADA) codes; and (4) be in U.S. Dollar currency. Reimbursement will be based on the applicable Scheduled Fee amounts.

P. RECOVERY OF OVERPAYMENTS: We reserve the right to deduct from any benefits properly payable under this Policy the amount of any payment that has been made:

1. In error; or
2. pursuant to a misstatement contained in a proof of loss; or
3. pursuant to fraud or misrepresentation made to obtain coverage under this Policy within two (2) years after the date such coverage commences; or
4. with respect to an ineligible person; or
5. pursuant to a claim for which benefits are recoverable under any Policy or act of law providing coverage for occupational injury or disease to the extent that such benefits are recovered.

Such deduction may be against any future claim for benefits under the Policy made by a Covered Person if claim payments previously were made with respect to a Covered Person.

IN WITNESS WHEREOF, We have caused this Policy to be signed by Our President and Secretary.



Secretary

President

Countersigned by: _____

(A licensed resident agent where required by law)

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Starmount Life Insurance Company

[Home Office: 7800 Office Park Blvd., P.O. Box 98100, Baton Rouge, LA 70898-9100
Administrative Office: AlwaysCare Benefits, Inc., 7800 Office Park Blvd, PO Drawer 14389
Baton Rouge, LA 70898-4389]
Toll Free Telephone No: 1-888-729-5433

LIMITED BENEFITS HEALTH INSURANCE
DENTAL INSURANCE POLICY
[with Vision and TMJ Benefits Rider]

The Named Insured as shown in the Policy Schedule will be referred to as "You", "Your" or "Yours". Starmount Life Insurance Company will be referred to as "We", "Our" or "Us".

IMPORTANT
This is a dental policy [with [Vision] and [TMJ Benefits Rider]]. Read it carefully with the Outline of Coverage, if applicable.

CONSIDERATION
This policy is issued in consideration of the statements made in Your application and the payment of the premium shown in the Policy Schedule. A copy of Your application is attached and is part of this policy. The following paragraphs set forth the insurance benefits, limitations and exclusions, definitions of terms, and other provisions.

TERM
The term of this policy begins at noon, standard time, at the place where You reside on the effective date shown in the Policy Schedule. It ends at noon, the same standard time, on the first renewal date. Each renewal term ends at noon, the same standard time, on the next following renewal date. Renewal dates are determined by the mode of payment. The mode of payment for the original term of the policy is shown in the Policy Schedule. An annual premium will maintain the policy in force for 12 months, semiannual for six months, quarterly for three months.

30-DAY RIGHT TO EXAMINE THIS POLICY
It is important to Us that You are satisfied with this policy and that it meets Your insurance goals. If You are not satisfied, You may return it within 30 days after You receive it. You will receive a full refund of all premiums paid, and Your policy will be void from its effective date. If You return the policy, please note in writing: "This policy is returned for cancellation and refund of premium."

IMPORTANT NOTICE
Please read Your application attached to this policy. This policy is issued on the basis that the information shown on the application is correct and complete to the best of Your knowledge and belief. Carefully check the application. Write to Us within 30 days of the date You receive this policy if any information shown on it is not correct or complete. Incorrect information can result in the denial of a claim or termination of the policy. No duly licensed agent may change this policy or waive any of its provisions.

GUARANTEED RENEWABLE. WE HAVE THE RIGHT TO CHANGE PREMIUM RATES.
You can keep Your policy in force as long as You pay Your premium on time. It must be paid by the due date or during the 31 day Grace Period. We may change the premium rates effective at renewal dates for Each Subsequent Policy Year. We will not change Your premium unless the same change is made on all policies of this form in the state where you live. We will notify You in writing at Your last known address at least 30 days before the change becomes effective.

THIS IS A NON-PARTICIPATING POLICY

INDEX

POLICY SCHEDULE

Insert Policy Schedule here.

Part 1
DEFINITIONS

A. CLAIM: a request for payment of benefits under this policy.

B. COVERED DENTAL EXPENSE: is the lesser of the actual charge or the Schedule Amount.

C. COVERED DENTAL PROCEDURE: any procedure listed in the Schedule of Covered Procedures.

D. COVERED PERSONS: are any persons listed in the Policy Schedule.

Newborn children are automatically covered under the terms of the policy from the moment of birth, and adopted children are covered from the date of petition. Coverage for newborn or adopted children will be in effect until the 31st day following the date of such event. If You desire uninterrupted coverage for a newborn or an adopted child, You must notify Us within 31 days of the child's birth or the date of petition for adoption.

Upon notification, We will convert this policy to the Type of Coverage You requested and advise You of the additional premium due, if any. If You wish any other person to be covered after the effective date of the policy, You must apply for such coverage, and that person must be added by endorsement. Insurance for persons added by endorsement becomes effective on the date specified on the endorsement.

The insurance of any Dependent Child will terminate on the policy anniversary date following the end of the month of the child's 26th birthday, the child's marriage, or at the time the child no longer qualifies as a legal dependent for tax exemption purposes under the Unites States Revenue Service Tax Code, whichever occurs first. Termination will be without prejudice to any claim originating prior hereto. Our acceptance of premium after such date will be considered as premium for only the remaining persons who qualify as covered persons under the policy. Coverage provided under a Type of Coverage listed in the Policy Schedule, which includes Dependents, will include any other unmarried dependent child, regardless of age, who is incapable of self-sustaining employment by reason of mental retardation or physical handicap and who became so incapacitated before age 26. You must furnish proof of such incapacity and dependency to Us within 31 days of the dependent child's 26th birthday. At Our request You must furnish proof of loss of continued incapacity and dependency, but not more often than annually after the two-year period following the end of the month of the child's 26th birthday.

In the event of Your death, Your spouse, if covered by this policy, will become the Named Insured.

E. DENTAL HYGIENIST: a legally qualified person, other than a member of Your Immediate Family, who is licensed by the state to treat the type of condition for which a claim is made.

F. DENTIST: a legally qualified person, other than a member of Your Immediate Family, who is licensed by the state to treat the type of condition for which a claim is made.

G. DEPENDENT CHILDREN: are Your natural children, stepchildren or legally adopted children who are unmarried, who are under 19 years of age and who qualify as legal dependents for tax exemption purposes under the United States Internal Revenue Service Tax Code. Coverage of a dependent child will be extended through age 24 if he/she is enrolled as a full-time student in an accredited post-secondary institution of higher learning for five calendar months in that calendar year or, if not enrolled, would have been eligible to enroll and was prevented from enrolling due to sickness or injury. Children born to dependent children of You or Your spouse are not covered under this policy.

H. FUNCTIONING NATURAL TOOTH: means a tooth which is performing its normal role in the mastication (chewing) process in the covered person's upper or lower arch and which is opposed in the person's other arch by another tooth or prosthetic (i.e. artificial) replacement. Third molars are not considered Functioning Natural Teeth for purposes of this policy.

I. IMMEDIATE FAMILY: anyone related to You in the following manner: spouse; brother or sister (includes stepbrother and stepsister); children (includes stepchildren); parents(s) (includes stepparents); grandchildren; father- or mother-in-law;) and spouses as applicable, of any of these.

J. IN-NETWORK BENEFITS: The dental benefits provided under this Certificate for Covered Procedures that are provided by a Participating Provider.

K. NON-PARTICIPATING PROVIDER: A dentist or dental hygienist who is not a Participating Provider. These Non-Participating Providers have not entered into an agreement with us to limit their charges.

L. OUT-OF-NETWORK BENEFITS: The dental benefits provided under this Certificate for Covered Procedures that are not provided by a Participating Provider.

M. PARTICIPATING PROVIDER: A dentist or dental hygienist who has been selected by Us for inclusion in the Participating Provider Program. These Participating Providers agree to accept Our Participating Provider Maximum Allowed Charges as payment in full for services rendered. When dental care is given by Participating Providers, the Insured will generally incur less out-of-pocket cost for services rendered.

N. PARTICIPATING PROVIDER PROGRAM: Our program to offer an Insured the opportunity to receive dental care from dentists who are designated by Us as Participating Providers.

O. PATRICIPATING PROVIDER PROGRAM DIRECTORY: The list which consists of selected Participating Providers who:

1. are located in Your area; and
2. have been selected by Us to be Participating Providers and part of the Participating Provider Program.

The list will be periodically updated.

P. POLICY YEAR: Policy Year includes the First Policy Year and each subsequent Policy Year.

1. **First Policy Year:** the period of time that begins on the effective date of coverage as shown in the Policy Schedule and ends 365 days from the effective date.

2. **Each Subsequent Policy Year:** every 12-month period thereafter.

Q. POLICY YEAR DEDUCTIBLE: the amount shown in the Policy Schedule. This amount applies to each Covered Person and must be satisfied once each Policy Year before benefits are payable for Covered Dental Expenses.

R. POLICY YEAR BENEFIT MAXIMUM: the amount shown in the Policy Schedule. This amount applies to each Covered Person and is the maximum amount paid for Covered Dental Expenses per Policy Year.

S. RENEWAL DATE: is the yearly anniversary date of the policy. The first Renewal Date is 365 days from the effective date of coverage. Each subsequent Renewal Date is 365 days from the prior Renewal Date.

T. SCHEDULE AMOUNT: the amount shown in the Schedule of Covered Procedures.

U. SCHEDULE OF COVERED PROCEDURES: a listing of all Covered Dental Procedures and the corresponding Schedule Amounts.

V. TREATMENT PLAN: is the Dentist's report of recommended treatment on a form satisfactory to Us which:

a. itemizes the dental Services with ADA codes, dates of service(s) and charges required for the Necessary care of the mouth;

b. lists the charges for each Service; and

c. is accompanied by supporting pre-operative X-rays and any other appropriate diagnostic materials required by Us.

W. TYPE OF COVERAGE: (see Your Policy Schedule to determine the type of coverage in force)

X. WAITING PERIOD: the period after the effective date of coverage for which benefits are not payable. In the event of a reinstatement, all covered persons will be subject to new Waiting Periods beginning with the effective date of reinstatement. If a dependent is added by endorsement, the Waiting Period will begin from the effective date of the addition. The Waiting Period will vary based on type of service (see the Policy Schedule).

Part 2
DESCRIPTION OF BENEFITS

DENTAL BENEFITS: Subject to the Waiting Period, Policy Year Deductible, Policy Year Benefit Maximum, listed in the Policy Schedule, and Limitations and Exclusions, we will pay for services listed in the Schedule of Covered Procedures up to Covered Dental Expense amount when a charge is incurred for a Covered Dental Procedure that occurs while coverage is in force.

CHOICE OF PROVIDERS: An Covered Person may choose the services of a Participating Provider who is either a Participating Provider or a Non-Participating Provider. Benefits under this Policy are determined and payable in either case. If a Participating Provider is chosen, the Covered Person will generally incur less out-of-pocket cost.

Part 3
LIMITATIONS AND EXCLUSIONS

A. This policy does not cover losses caused by or resulting from any of the following. In addition, the procedures listed below will not be recognized toward satisfaction of any Policy Year Deductible.

1. Any procedure or service not shown on the Schedule of Covered Procedures or the Policy Schedule.
2. Amounts in excess of the Policy Year Benefit Maximum.
3. Services or supplies We consider being experimental or investigative.
4. Any injury or illness when covered under Worker's Compensation or similar law, or which is work related.
5. Services received before a Covered Person's effective date, including started but not completed services.
6. Services received after, or started but not completed within 30 days of a Covered Person's coverage ending.
7. Charges for dental services performed by other than a licensed dentist or dental hygienist.
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9. Repairs or adjustments to dental work within six months of the initial work.
10. Replacement prosthetics within seven years of last placement.
11. Treatment involving crowns for a given tooth within seven years of last placement, regardless of the type of crown.
12. Replacement for inlays or onlays for a given tooth within seven years of last placement.
13. Any services performed for convenience or cosmetic purposes.
14. Any charge for a service required as a result of disease or injury that is due to war or an act of war (whether declared or undeclared); taking part in an insurrection or riot; the commission or attempted commission of a crime; an intentionally self-inflicted injury or attempted suicide while sane or insane.
15. Services performed by a Dentist who is a member of the covered person's Immediate Family.
16. [Except as provided under the TMJ Expense Rider.]

B. No benefits will be paid for replacement of teeth missing prior to the effective date of coverage.
C. No benefits will be paid for the initial placement of removable full or partial dentures, unless it includes the replacement of a Functioning Natural Tooth extracted while the covered person is insured under this policy.
D. No benefits will be paid for the initial placement of a fixed partial denture including a Maryland Bridge, unless it includes the replacement of a Functioning Natural Tooth extracted while the covered person is insured under this policy.
E. Federal, State or local taxes are not included as part of a Covered Dental Expense.
F. See the Schedule of Covered Dental Procedures for all specific procedure limitations.

Part 4
INSURANCE WITH OTHER INSURERS

If there is other valid coverage, not with Us, providing benefits for the same loss on a provision of service basis or on an expense incurred basis and of which We have not been given written notice prior to the occurrence or commencement of loss, the only liability under any expense incurred coverage of this Policy will be for the proportion of the loss as the amount which would otherwise have been payable under this policy plus the total of the like amounts under all the other valid coverages for the same loss of which We had notice bears to the total like amounts under all valid coverages for the loss, and for the return of the portion of the premiums paid as shall exceed the pro-rata portion for the amount so determined. For the purpose of applying this provision when other coverage is on a

provision of service basis, the "like amount" of the other coverage shall be taken as the amount that the services rendered would have cost in the absence of the coverage.

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RIGHT OF CONVERSION

If You or Your spouse dissolve Your marriage by a valid decree of dissolution of marriage and Your spouse was a Covered Person, then Your ex-spouse can apply for and receive, without evidence of insurability, a policy providing coverage not greater than the terminated coverage. To obtain the policy, Your ex-spouse must make application to Us within 60 days following the entry of the decree of dissolution of marriage. If such dissolution of marriage occurs, the Named Insured under this policy at the time of dissolution will retain that status. Any covered dependent may be covered under either policy, but not both.

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GENERAL POLICY PROVISIONS

A. ENTIRE CONTRACT; CHANGES: This policy, together with the application, endorsements, benefit agreements, riders and attached papers, if any, is the entire contract of insurance. No change in the policy is valid until approved in writing by Our president and secretary. This approval must be noted on or attached hereto. No duly licensed agent may change this policy or waive any of its provisions.

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F. CLAIM FORMS: When We receive a notice of claim, We will send the claimant forms for filing proof of loss. If the forms are not given to You within 10 working days after the giving of such notice, You will meet the proof of loss requirements by submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

G. PROOF OF LOSS: Written proof of loss must be given to Us in case of claim for loss for which this Policy provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which We are liable, and in case of claim for any other loss within 90 days after the date of such loss. Failure to furnish such proof within the time required will not invalidate or reduce any claim if it was not reasonably possible to give proof within such time. However, such proof must be furnished as soon as reasonably possible and in no event (except in the absence of legal capacity) later than 12 months from the time of proof is otherwise required.

H. TIME OF PAYMENT OF CLAIMS: benefits payable under this policy will be paid immediately upon Our receipt of written proof of loss.

I. PAYMENT OF CLAIMS: All benefits will be payable to You unless assigned by You or by operation of law. Any accrued benefits unpaid at Your death will be paid to Your estate.

J. CLAIMS REVIEW PROCEDURE: If a claim is denied in whole or in part, You may request a review of the claim. The request must be in writing and must be made within 6 months after the claim was denied. Send the request to Us at P.O. Box 98100, Baton Rouge, LA 70898-9100. The request should contain any facts that the Insured considers important to the review. We will review the claims decision and send a response in writing within thirty (30) days. If the denial of benefits is confirmed, You will be told the reasons for the decision.

K. LEGAL ACTIONS: No legal action may be brought to recover on this policy within 60 days after written proof of loss has been given as required. No such action may be brought after six years from the time written proof of loss is required to be given.

L. CONFORMITY WITH STATE AND FEDERAL STATUTES: Any provisions of this policy that on its effective date is in conflict with the statutes of the state in which it was issue or with any federal statutes is hereby amended to conform to the minimum requirements of such statutes.

M. OTHER INSURANCE WITH THIS INSURER: If any person is covered under more than one policy or rider from Us, only the one chosen by You, Your beneficiary or Your estate, as the case may be, will be effective. We will return all premiums paid for that person for all other dental coverage from the date of duplication.

N. PRE-ESTIMATION OF BENEFITS: Whenever the estimated cost of a recommended dental Treatment Plan exceeds $300, the Treatment Plan may be submitted to Us for review before treatment begins. The Treatment Plan should be accompanied by supporting pre-operative X-rays and any other appropriate diagnostic materials that We or Our dental consultants request. We will notify the covered person and the attending Dentist of the estimated benefits payable based upon the Treatment Plan. In determining the amount of benefits payable, consideration will be given to alternate procedures that may accomplish a professionally satisfactory result. If the covered person and His Dentist decide on a more expensive method of treatment than that pre-estimated by Us, benefits will be paid for the more costly treatment, but only up to the Policy liability for the less expensive alternate Service. We will not pay the excess amount. Since this may result in significant out-of-pocket expense, We strongly encourage You to follow the pre-estimation procedure for any Treatment Plan which will exceed $300 in cost. Pre-Estimation of Benefits is not a promise of payment.

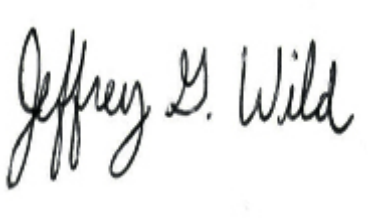
O. SERVICES PERFORMED OUTSIDE THE U.S.A.: Any Claim submitted for procedures outside the U.S.A. must: (1) be for a Covered Procedure, as defined; (2) be supplied in English; (3) use American Dental Association (ADA) codes; and (4) be in U.S. Dollar currency. Reimbursement will be based on the applicable Scheduled Fee amounts.

P. RECOVERY OF OVERPAYMENTS: We reserve the right to deduct from any benefits properly payable under this Policy the amount of any payment that has been made:

1. In error; or
2. pursuant to a misstatement contained in a proof of loss; or
3. pursuant to fraud or misrepresentation made to obtain coverage under this Policy within two (2) years after the date such coverage commences; or
4. with respect to an ineligible person; or
5. pursuant to a claim for which benefits are recoverable under any Policy or act of law providing coverage for occupational injury or disease to the extent that such benefits are recovered.

Such deduction may be against any future claim for benefits under the Policy made by a Covered Person if claim payments previously were made with respect to a Covered Person.

IN WITNESS WHEREOF, We have caused this Policy to be signed by Our President and Secretary.



Secretary

President

Countersigned by: _____

(A licensed resident agent where required by law)